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ABSTRACT

This document is a transcript of hearings concerning the Handicapped Individuals Services and Training Act that would provide funds for operation of the Helen Keller National Center for Deaf-Blind Youths and Adults, the Vinland National Center for Health-Sports and Physical Fitness for Handicapped Individuals, and other projects and services for the deaf and handicapped persons. During the hearings, professionals who work with handicapped persons--program directors, rehabilitation services directors, handicapped persons, and public citizens--expressed their support for the services that this bill would provide, detailing some of the benefits that the programs already in existence have given and citing the need for additional services. One service in particular that would be dropped if the act is not passed is that of film captioning for deaf persons. Some of the witnesses questioned the need for the Vinland Center. They thought its cost would be excessive and its services duplicative; others supported the Vinland Center. The transcript also contains prepared statements submitted by the witnesses and other concerned persons, along with the text of the act. (KC)

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HANDICAPPED INDIVIDUALS SERVICES AND TRAINING ACT

HEARING

BEFORE THE

SUBCOMMITTEE ON SELECT EDUCATION

OF THE

COMMITTEE ON EDUCATION AND LABOR
HOUSE OF REPRESENTATIVES

NINETY-SEVENTH CONGRESS

SECOND SESSION

ON

H.R. 6820

TO PROVIDE FOR THE OPERATION OF THE HELEN KELLER NATIONAL CENTER FOR DEAF-BLIND YOUTHS AND ADULTS, TO PROVIDE FOR THE OPERATION OF THE VINLAND NATIONAL CENTER FOR HEALTH-SPORTS AND PHYSICAL FITNESS FOR HANDICAPPED INDIVIDUALS AND CERTAIN OTHER CENTERS WHICH ASSIST HANDICAPPED INDIVIDUALS IN ACHIEVING GREATER INDEPENDENCE, AND TO ASSURE CONTINUED NATIONAL SUPPORT FOR OTHER PROJECTS AND SERVICES FOR THE DEAF AND OTHER HANDICAPPED INDIVIDUALS

HEARING HELD IN ST. PAUL, MINN., AND LORETTO, MINN. ON SEPTEMBER 2, 1982

Printed for the use of the Committee on Education and Labor

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HANDICAPPED INDIVIDUALS SERVICES AND TRAINING ACT

THURSDAY, SEPTEMBER 2, 1982

House of Representatives,
Subcommittee on Select Education,
Committee on Education and Labor,
St. Paul, Minn.

The subcommittee met, pursuant to call, at 9:30 a.m., in the auditorium, St. Paul Technical Vocational Institute, 235 Marshall Avenue, St. Paul, Minn., Hon. Austin J. Murphy (chairman of the subcommittee) presiding.

Members present: Representatives Murphy and Erdahl.

Also present: Senator Rudy Boschwitz.

Staff present: Cheryl Kinsey, majority staff member; Jane Baird, full committee staff; and Pat Morrissey, minority legislative associate.

Mr. Erdahl [presiding]. I will ask the people on the first panel if they could come up to the table to our right, or if people would rather testify from where they are, we can accommodate that.

I think that we can be quite informal and go ahead. Austin Murphy, the chairman of the House Committee on Education and Labor, Subcommittee on Select Education, is still coming in on a plane, and one of my staff people is picking him up and hopefully he will be along fairly soon.

He asked me, as the ranking member of the subcommittee, to get going today. We tried to make some accommodation for concerns people had specifically about the Vinland Center, and other witnesses had been scheduled before.

I should also apologize—we haven't gotten into much substance yet. I would like to make a brief opening statement in talking about House Resolution 6820, a bill that I and several others have introduced before the Congress in the House and a similar bill has been introduced in the Senate.

[The text of H.R. 6820 follows:]

[H.R. 6820, 97th Cong., 2d sess.]

A BILL To provide for the operation of the Helen Keller National Center for Deaf-Blind Youths and Adults, to provide for the operation of the Vinland National Center for Healthsports and Physical Fitness for Handicapped Individuals and certain other centers which assist handicapped individuals in achieving greater independence, and to assure continued national support for other projects and services for the deaf and other handicapped individuals

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

7

SHORT TITLE

SECTION 1. This Act may be cited as the "Handicapped Individuals Services and Training Act".

TITLE I—HELEN KELLER NATIONAL CENTER FOR DEAF-BLIND YOUTHS AND ADULTS

STATEMENT OF FINDINGS

SEC. 101. The Congress hereby finds that—

(1) deaf-blindness is among the most severe of all disabilities, and there is great need for services and training to assist deaf-blind individuals in attaining the highest possible level of development;

(2) due to the rubella epidemic of the 1960's and advancements in medical technology which have sustained the lives of many severely disabled individuals, including deaf-blind individuals, the need for services for such individuals is even more pressing now than in the past;

(3) enabling deaf-blind individuals to become self-sustaining, independent, and employed through services and training will benefit the Nation, both economically and socially;

(4) the Helen Keller National Center for Deaf-Blind Youths and Adults is a vital national resource for meeting the needs of deaf-blind individuals, and no State has the necessary facilities or personnel to meet such needs;

(5) the Federal Government has invested approximately $10,000,000 in capital, equipment, and operating funds for the Center; and

(6) it is in the national interest to continue to provide support to the Center, and it is a proper function of the Federal Government to be the primary source of support for the Center.

ESTABLISHMENT OF CENTER

SEC. 102. There hereby is established the Helen Keller National Center for Deaf-Blind Youths and Adults. It shall be the purpose of the Center—

(1) to provide specialized intensive services, and other services, needed to encourage maximum personal development of deaf-blind individuals, both at the Center and throughout the United States;

(2) to train professionals and allied personnel to provide services to deaf-blind individuals, both at the Center and throughout the United States; and

(3) to conduct applied research, development, and demonstrations with respect to communication techniques, teaching methods, aids and devices, and delivery of services.

AUDIT, MONITORING, AND EVALUATION

SEC. 103. (a) The accounts and records of the Center shall be audited annually by an independent auditor, and the report of each such audit shall be timely submitted to the Secretary.

(b) The Secretary shall ensure that the program of services and training conducted by the Center shall be monitored on a regular basis. The Secretary shall further ensure that an evaluation of the operation of the Center shall be conducted annually, and a written report of such evaluation shall be submitted to the President and to the Congress not later than one hundred and eighty days following the close of each fiscal year for which such evaluation is conducted. The first such report shall be submitted not later than March 31, 1985.

AUTHORIZATION OF APPROPRIATIONS

SEC. 104. (a) There are authorized to be appropriated $3,500,000 for fiscal year 1984, and such sums as may be necessary for each succeeding fiscal year, for the operation and maintenance of the Center. Such sums shall be available without fiscal year limitation.

(b) Sums appropriated under subsection (a) shall be used only to carry out the purposes of this title, in accordance with such guidelines or regulations as the Secretary may prescribe.

SAVINGS PROVISIONS

SEC. 105. Nothing in this Act shall affect or modify any existing or future agreement between the Secretary or the head of any other department or instrumentality of the Federal Government and the Industrial Home for the Blind, Incorporated, or its successors or assigns, with respect to the Helen Keller National Center for Deaf-Blind Youths and Adults.

TITLE II—VINLAND NATIONAL CENTER FOR HEALTHSPORTS AND PHYSICAL FITNESS FOR HANDICAPPED INDIVIDUALS

STATEMENT OF FINDINGS

SEC. 201. The Congress hereby finds that—

(1) of the 35,000,000 Americans characterized as handicapped, few have had the opportunity to participate in healthsport and physical fitness activities for handicapped individuals;

(2) few persons who work with handicapped individuals have knowledge or training regarding the development of healthsport and physical fitness activities or the provision of such opportunities for handicapped individuals;

(3) financial support for healthsport and physical fitness activities adapted for handicapped individuals has been extremely limited, and when available is most likely provided to school aged or institutionalized handicapped individuals;

(4) basic and applied research is needed to establish the short-term and long-term benefits of exposure to information about and participation in healthsport and physical fitness activities for handicapped individuals;

(5) information about healthsport and physical fitness activities for handicapped individuals must be more widely disseminated;

(6) the Federal Government, in recognition of the bicentennial gift from the Government of Norway, which contributed to the creation of the Vinland National Center for Healthsports and Physical Fitness, should provide interim financial assistance to enable the Center to complete its construction and program plan and become fully operational;

(7) the Federal Government, having invested $1,187,000 since 1978 in the Center which fostered matching funds from the private sector, is likely to encourage additional support from the private sector and other sources if it makes a specific fiscal commitment to the Center for a specified period;

(8) it is in the national interest to provide interim financial support for the Center so that handicapped individuals may develop more knowledge of the benefits of sound physical fitness and have access to opportunities to demonstrate and expand their independence through healthsport activities, and thus such individuals may be more able to lead productive lives; and

(9) the provisions of this title complement the intent of the Education of the Handicapped Act and the Rehabilitation Act of 1973, in that such provisions reaffirm the congressional intent to promote a full range of opportunities for handicapped individuals.

ESTABLISHMENT OF CENTER

SEC. 202. There hereby is established the Vinland National Center for Healthsports and Physical Fitness for Handicapped Individuals. It shall be the purpose of the Center—

(1) to provide training in healthsports and physical fitness for handicapped individuals at the Center and throughout the United States;

(2) to provide training and technical assistance to persons who wish to establish healthsport and physical fitness activities and programs for handicapped individuals in States and local communities, and to provide such training and assistance at the Center and throughout the United States;

(3) to conduct basic and applied research in healthsports and physical fitness and related areas as they pertain to handicapped individuals; and

(4) to collect and disseminate information, including findings of research conducted by the Center, relating to healthsports and physical fitness throughout the United States.

NATIONAL ADVISORY PANEL

SEC. 203. (a) The Center shall establish a National Advisory Panel on Healthsports and Physical Fitness for Handicapped Individuals, which shall be composed of members who have knowledge and expertise relating to the needs of handicapped individuals, healthsports, and physical fitness. The membership of the Panel shall include individuals from public schools, vocational rehabilitation programs, advocacy groups, community service agencies, and the private sector. The Center shall attempt to obtain broad-based geographical representation in the membership of the Panel.

(b) The Panel shall—

(1) offer suggestions for proposed Center program activities;

(2) review and comment upon plans and reports before their submission to the Secretary of Education;

(3) identify sources of non-Federal support; and

(4) promote the concept of healthsports and physical fitness for handicapped individuals.

(c) The Panel shall not be subject to the provisions of the Federal Advisory Committee Act.

CONSTRUCTION AND PROGRAM PLANS; REPORTS

SEC. 204. (a)(1) The Center shall provide to the Secretary, not later than the beginning of each fiscal year, a plan which (A) describes proposed construction and program activities to be conducted in such fiscal year; and (B) contains a detailed budget for such fiscal year, including a description of anticipated sources of non-Federal support and the anticipated amount of such support.

(2) Each plan submitted under paragraph (1), other than the initial plan, shall be accompanied by a report regarding operations of the Center during the preceding fiscal year.

(b) The Secretary shall not release any funds to the Center for any fiscal year unless the Secretary has received the plan and report required in subsection (a). The Secretary, upon receiving the reviewing such plans and reports, may request clarification of the information contained in such plans and reports before the release of funds for the next fiscal year. The Secretary, in cooperation with the Center, shall develop an outline of the information to be included in such plans and reports.

EXPENDITURES OF CENTER FROM NON-FEDERAL SUPPORT

SEC. 205. (a) Except as provided in subsection (b), the percentage of the total expenses of the Center which shall be met through the use of non-Federal support shall be as follows: (1) 10 per centum for fiscal year 1984; (2) 25 per centum for fiscal year 1985; (3) 33 per centum for fiscal year 1986; (4) 50 per centum for fiscal year 1987; and (5) 75 per centum for fiscal year 1988.

(b) The percentage of the total expenses of the Center for the construction of facilities which shall be met through the use of non-Federal support shall be 50 per centum for each of the fiscal years 1984 and 1985.

(c) The Secretary periodically shall review, during each fiscal year, expenditures made by the Center and the amount of non-Federal support received by the Center in order to ensure that the Center complies with the requirements of subsection (a) and subsection (b). The Secretary shall disburse funds appropriated under section 209 to the Center on a quarterly basis during each fiscal year, making such adjustments in such disbursements as may be necessary to ensure such compliance.

LIMITS ON USE OF FUNDS

SEC. 206. (a) Funds authorized to be appropriated in section 209 may be used only for (1) personnel salaries and expenses of the Center, including fees for consultants; (2) administration of the Center; (3) personnel travel; (4) program development; (5) the purchase and maintenance of equipment; (6) research; (7) construction and maintenance of Center facilities; (8) the rental of facilities; (9) the preparation of reports and publications; and (10) expenses of the Panel.

(b) Funds authorized to be appropriated in section 209 shall not be used to (1) pay travel expenses of persons (other than personnel of the Center) who participate in activities and programs of the Center; or (2) pay stipends to or fees for persons (other than personnel and consultants employed by the Center) who participate in activities and programs of the Center.

AUDIT, MONITORING, AND EVALUATION

SEC. 207. (a) The accounts and records of the Center shall be audited annually by an independent auditor, and the report of each such audit shall be submitted to the Secretary not later than ninety days following the end of the fiscal year involved.

(b) The Secretary shall ensure that the services, training, and other activities of the Center shall be monitored annually. Onsite monitoring shall be conducted at least three times during the period beginning on October 1, 1983, and ending on September 30, 1988. The Secretary further shall ensure that an evaluation of the services, training, and other activities of the Center will be conducted annually, and a written report shall be submitted to the President and the Congress not later than one hundred and eighty days after the end of each fiscal year.

ADMINISTRATION OF TITLE

SEC. 208. The provisions of this title shall be administered by the Secretary, acting through the Commissioner of the Rehabilitation Services Administration.

AUTHORIZATION OF APPROPRIATIONS

SEC. 209. There are authorized to be appropriated to carry out the provisions of this title $2,650,000 for fiscal year 1984 (of which $2,000,000 is authorized for the construction of facilities for the Center), $1,650,000 for fiscal year 1985 (of which $1,000,000 is authorized for the construction of facilities for the Center), $400,000 for fiscal year 1986, $300,000 for fiscal year 1987, and $300,000 for fiscal year 1988.

TITLE III—REGIONAL POSTSECONDARY EDUCATIONAL PROGRAMS

STATEMENT OF FINDINGS

SEC. 301. The Congress hereby finds that—

(1) deafness is a major learning handicap and there is a great need for postsecondary educational programs to assist deaf individuals in attaining the highest possible level of development;

(2) deaf individuals have a right to participate in postsecondary education;

(3) deafness is a low-incidence handicap, and this national constituency is most appropriately served by the existing four regional education programs;

(4) the success of deaf students enrolled in the four regional education programs is cost effective and profitmaking when a comparison is made of Federal income taxes paid with the Federal funds invested to provide career training; and

(5) it is in the national interest to continue to provide support for the four regional education programs and other institutions of higher education and appropriate nonprofit agencies, and it is the proper function of the Federal Government to provide such support.

ESTABLISHMENT AND ADMINISTRATION OF PROGRAMS

SEC. 302. (a) The Secretary is authorized to make grants to and enter into contracts with (1) the California State University at Northridge, California, the Seattle, Washington, Central Community College, the Saint Paul, Minnesota, Vocational Institute, and Delgado College at New Orleans, Louisiana, for the purpose of establishing and maintaining regional education programs under subsection (b); and (2) other institutions of higher education and appropriate nonprofit education agencies, for the purpose specified in subsection (c).

(b) It shall be the purpose of the regional education programs—

(1) to provide academic, vocational, and supportive education services for deaf students; and

(2) to facilitate occupational placement of graduates.

(c) Any institutions or agency receiving funds in accordance with any grant or contract under subsection (a)(2) shall use such funds to develop model postsecondary programs for serving handicapped individuals (other than deaf individuals).

(d) In making grants or entering into contracts under this section, the Secretary shall give priority to—

(1) programs serving multi-state regions or large population centers;

(2) programs adapting existing programs of vocational, technical, postsecondary, or adult education to special needs of handicapped individuals;

(3) programs designed to serve areas where a need for such services is clearly demonstrated; and

(4) programs that have demonstrated proven effectiveness.

AUDIT, MONITORING, AND EVALUATION

SEC. 303. (a) The accounts and records of the institutions and agencies receiving funds under this title shall be auditied annually by an independent auditor, and the report of each such audit shall be submitted to the Secretary not later than ninety days following the end of the fiscal year involved.

(b) The Secretary shall ensure that at least three onsite visitations are conducted at the facilities of each of the entities specified in section 302(a)(1) during the period beginning on October 1, 1983, and ending on September 30, 1988, for the purpose of monitoring and evaluating the operation of the regional education programs.

(c) The Secretary shall conduct, either directly or by contract with indpendent organizations, a thorough and continuing evaluation of the effectiveness of each program assisted under this title.

ADMINISTRATION OF TITLE

SEC. 304. The provisions of this title shall be administered by the Secretary, acting through the Director of Special Education Programs.

AUTHORIZATION OF APPROPRIATIONS

SEC. 305. (a) There authorized to be appropriated to carry out the provisions of this title $4,000,000 for each of the fiscal years 1984, 1985, 1986, 1987, and 1988.

(b)(1) Of the funds appropriated under subsection (a) for any fiscal year, eighty percent of such funds shall be made available for the regional education programs. The proportion of the funds appropriate for such programs for any fiscal year which is received by any entity specified in section 302(a)(1) shall be the same as the proportion of funds received by such entity from the funds appropriated for such programs for fiscal year 1983.

(2) The remainder of the funds appropriated under subsection (a) for any fiscal year shall be made available to the entities specified in section 302(a)(2).

TITLE IV—CAPTIONED FILMS AND RELATED SERVICES FOR DEAF AND OTHER HANDICAPPED INDIVIDUALS

STATEMENT OF FINDINGS

SEC. 401. The Congress hereby finds that—

(1) the Federal Government has a responsibility to promote the general welfare of deaf and other handicapped individuals by adapting and distributing existing media and materials in a way which assures broader accessibility for such individuals;

(2) the adaptation and distribution of media for handicapped individuals will provide enriching educational and cultural experiences for such individuals, and should contribute to their understanding of and participation in their environment; and

(3) in order to promote accessibility to adapted media and materials, distribution of such materials should not be limited to handicapped individuals but should be extended to teachers, parents, employers, and other persons directly involved in the advancement of handicapped individuals.

ESTABLISHMENT OF SERVICES

SEC. 402. (a) The Secretary shall establish a loan service of captioned films and educational media for the purpose of making such materials available in the United States for nonprofit purposes to handicapped individuals, parents of handicapped individuals, and other persons directly involved in activities for the advancement of the handicapped, in accordance with regulations prescribed by the Secretary.

(b) The Secretary is authorized to—

(1) acquire films (or rights thereto) and other educational media by purchase, lease, or gift;

(2) acquire by lease or purchase equipment necessary to the administration of this title;

(3) provide, by grant or contract, for the captioning of films;

(4) provide, by grant or contract, for the distribution of captioned films and other educational media and equipment through State schools for the handicapped and such other agencies as the Secretary may deem appropriate ot serve as local or regional centers for such distribution;

(5) provide, by grant or contract, for the conduct of activities related to the use of educational and training films and other educational media for the handicapped, for the adaption and distribution of educational and training films and other educational media for the handicapped;

(6) utilize the facilities and services of other governmental agencies; and

(7) accept gifts, contributions, and voluntary and uncompensated services of individuals and organizations.

ADMINISTRATION OF TITLE

SEC. 403. The provisions of this title shall be administered by the Secretary, acting through the Assistant Secretary for Special Education and Rehabilitation Services.

AUTHORIZATION OF APPROPRIATIONS

SEC. 404. There are authorized to be appropriated $17,500,000 for fiscal year 1984, and such sums as may be necessary for each succeeding fiscal year, for the provision of services under this title. Such sums shall be available without fiscal year limitation.

TITLE V—GENERAL PROVISIONS

DEFINITIONS

SEC. 501. For purposes of this Act:

(1) The term "Center" means—

(A) for purposes of title I, the Helen Keller National Center for Deaf-Blind Youth and Adults, as such facility and its affiliated network (i) was established under an agreement approved in 1969 by the Secretary of Health, Education, and Welfare; (ii) was continued pursuant to section 313 of the Rehabilitation Act of 1973; and (iii) is further continued under title I; and

(B) for purposes of title II, the Vinland National Center for Healthsports and Physical Fitness for Handicapped Individuals established in section 202.

(2) The term "deaf-blind individual" means an individual whose combined visual and auditory losses are so substantial as to cause extreme difficulty in learning, as further defined by the Secretary in regulations or guidelines.

(3) The term "handicapped individual" means any individual who (A) has a physical or mental impairment which substantially limits one or more of the major life activities of such individual; (B) has a record of such an impairment; or (C) is regarded as having such an impairment.

(4) The term "healthsport" means any technique or procedure which (A) allows most sports to be adapted so that handicapped individuals may directly and actively participate in them; and (B) is part of a comprehensive learning experience or rehabilitation process which offers an opportunity to improve physical, social, and emotional fitness, develop medical self-care skills, enhance self-reliance, promote employability, and teach positive use of leisure and recreation time.

(5)(A) The term "institution of higher education" means an educational institution in any State which—

(i) admits as regular students only individuals having a certificate of graduation from a high school, or the recognized equivalent of such a certificate;

(ii) is legally authorized within such State to provide a program of education beyond high school;

(iii) provides an educational program for which it awards a bachelor's degree, or provides not less than a two-year program which is acceptable for full credit toward such a degree, or offers a two-year program in engineering, mathematics, or the physical or biological sciences which is designed to prepare the student to work as a technician and at a semiprofessional level in engineering, scientific, or other technical fields which require the understanding and application of basic engineering, scientific, or mathematical principles or knowledge;

(iv) is a public or other nonprofit institution; and

(v) is accredited by a nationally recognized accrediting agency or association listed by the Secretary under subparagraph (C) or, if not so accredited, is an institution whose credits are accepted, upon transfer, by not less than three institutions which are so accredited, for credit on the same basis as if transferred from an institution so accredited.

(B) In the case of institutions offering a two-year program in engineering, mathematics, or the physical or biological sciences which is designed to prepare the student to work as a technician and at a semiprofessional level in engineering, scientific, or technological fields which require the understanding and application of basic engineering, scientific, or mathematical principles or knowledge, if the Secretary determines that there is no nationally recognized accrediting agency or association qualified to accredit such institutions, he shall appoint an advisory committee, composed of individuals specially qualified to evaluate training provided by such institutions, which shall prescribe the standards of content, scope, and quality which shall be met in order to qualify such institutions to participate under this Act and shall also determine whether particular institutions meet such standards.

(C) For the purpose of this paragraph, the Secretary shall publish a list of nationally recognized accrediting agencies or associations which he determines to be reliable authority as to the quality of education or training offered.

(6) The term "non-Federal support" means any funds or inkind assistance, or both, that are not received directly from the Federal Government.

(7) The term "Panel" means the National Adivsory Panel on Healthsports and Physical Fitness for Handicapped Individuals established under section 203(a).

(8) The term "regional education program" means any program established and maintained by an entity specified in section 302(A)(1).

(9) The term "Secretary" means the Secretary of Education.

EFFECT ON OTHER LAWS

SEC. 502. Beginning on the effective date of this Act, section 313 of the Rehabilitation Act of 1973, section 626 of the Education of the Handicapped Act, and section 652 of the Education of the Handicapped Act shall cease to have any force or effect. Beginning on such effective date, the provisions of title IV shall be the exclusive authority for the administration of a loan service for captioned films and educational media by the Secretary.

EFFECTIVE DATE

SEC. 503. The provisions of this Act shall take effect on October 1, 1983.

Mr. ERDAHL. I would just like to go over notes I have here, so I don't neglect to say some things. We are going to try to accommodate as many witnesses as we can. We want to have a free and open discussion on various things involved. During the last 4 years, I have been in the Congress, and prior to that, I have had an ongoing concern for programs dealing with the handicapped, especially at the Federal level.

I am the ranking Republican on the House Subcommittee on Select Education, which deals with this area. The purpose of our meetings here in Minnesota—we will be having a meeting later this afternoon at the Vinland Center talking about that part of the bill—is to hear testimony from some people that might be handicapped and others that we might consider to be handicapped. We are looking at areas that might help us deal better as members of humanity with the problems and the potentials of those that have handicaps.

Mr. Austin Murphy from Pennsylvania, chairman of the subcommittee, will hopefully be joining us shortly. You know, in this time of fiscal austerity and budget cuts, and some of them, frankly, are hard to sustain and agree with, I think we need to stress the cost-efficiency of what we as society are willing to spend to help people live fuller and richer lives, not only for themselves, but for all of society, and stressing the abilities rather than the disabilities of individual people.

Of course, we have had the Year of the Disabled Persons. I might, as a personal note, say how I happened to get involved in this. Some years ago, I was secretary of state here in Minnesota—this applies specifically to the Vinland concept—and I had done some skiing in college and I was asked to participate as a sighted guide for a blind skier. The individual, and I don't think I violate his confidence by telling the story, with whom I skied that day was a successful radio businessman and had a family, from Texas.

I don't think he had ever seen snow before, and at the close of the day he told me that this was the happiest and most exciting day of his life because he had been able to achieve something that he and others didn't think he could ever do.

That set me up in the area. The bill that we will be talking about today deals with several areas. One of them would be a 5-year authorization for the Vinland National Center for Physical Fitness and Healthsports.

Another would be a 5-year reauthorization for the St. Paul Vocational Technical School program for the deaf and for three other postsecondary programs for the deaf in Washington State, Louisiana, and California. I know we have people from at least one of those schools and maybe others here today.

Finally, the bill provides a permanent authorization for the Helen Keller National Center for Deaf and Blind Youth and Adults and a permanent authorization for the Captioned Film Service.

Part of the reason that several of us got behind the bill in these areas as far as the reauthorization goes, was to give a little permanence to the programs, so we don't see the real possibility that every year they have to struggle with new funding and reauthorization.

We have had support for the bill from across the country, from people in Iowa, Massachusetts, South Carolina, and others, and from various associations. Some of this I will skip. We will hear from individuals who have benefited from the services of these various institutions and from many of my colleagues in the House and Senate.

You might ask why is the bill needed? Three of these programs must be reauthorized, or I suppose we could say they don't need to be reauthorized, they could be just dropped, but they need to be reauthorized by September 30, 1982, or they will expire, and reauthorizations take a lot of time.

So the fact of the matter is we are going to have to do something to maintain these programs either for just 1 year, temporarily, or we think if we could do it for a 5-year period it would be much better.

Most postsecondary training opportunities for the deaf will stop if we don't do something either temporarily or on a longer term basis.

The captioned film distribution will run out of money. There is a possibility that deaf and blind individuals will be placed in institutions. Handicapped individuals will sense that the larger society may support services for basic rehabilitation, but not for opportunities that have what we would call a life-enhancing capability.

States and local communities do not have the resources to absorb the costs of these programs. We hear much talk in Washington today about the concept of New Federalism. I think if those of us in the Congress think that, as we make significant cuts in these programs that apply so directly to the handicapped, whether we are talking about Public Law 94-142 or reauthorizations, if we think they are going to be picked up by State and local levels of government, we are being a bit naive or maybe more accurately, a bit deceitful, because you and I know it just isn't going to happen.

Again, I invite a frank and open discussion. I guess the one limitation that all of us has upon ourselves is time, which is good advice to myself to stop talking and start listening.

I know several of the witnesses have provided us with written testimony. My recommendation, if you feel comfortable doing so, would be to summarize it. Others of you who haven't submitted testimony might have it with you, and I hope that you will be willing and able to do the same thing.

With that, we have a panel that had requested to be heard I think dealing specifically with some concerns of the Vinland National Center. Again, I want to apologize to these people, because I had hoped that we could work it into the regular schedule.

Staff informs me that we had commitments already made, and probably our time is not going to be sufficient to take care of them. I will identify the staff people with me from Washington. On my left is Dr. Pat Morrissey, who works with me on the Subcommittee on Select Education.

To my right is Cheryl Kinsey, who works for the majority, for Mr. Murphy, and also Jane Baird, who works for the majority on the Education and Labor Committee in Washington.

I will list the members of the panel that I have on the sheet and welcome you here today. I am glad that you were willing to make this accommodation as well. Our court reporter is taking all this down and it will be in the record, and all your statements will be in the record, even if you summarize ones that have been prepared for us.

I will introduce the people that are here and please reintroduce yourselves for the record. Today, we have with us Dr. Dorothy Peters, a program consultant from Courage Center; Tom Haven is unable to be here. He is the president of the Metro Handicapped Coalition and had expressed an interest in being here.

Clint Schultz, the legislative advocate for the disabled; and Joyce Vincent, who is listed here as a private citizen.

So, whoever wants to proceed, we will be glad to listen to you. Maybe we will have some questions at the conclusion of your remarks.

STATEMENT OF CLINT SCHULTZ, LEGISLATIVE ADVOCATE FOR THE DISABLED

Mr. SCHULTZ. Thank you for the opportunity to testify before you, Mr. Chairman.

My name is Clint Schultz and I am also a member of the Metropolitan Handicapped Coalition and, as listed, a legislative advocate for the handicapped community in the metropolitan area of Minneapolis.

Mr. **Erdahl.** In other words, you will be making a statement on behalf of this group and maybe on behalf of the president, Mr. Haven?

Mr. **Schultz.** Yes. I have worked as an independent living specialist for the Metropolitan Center for Independent Living. I have been a career counselor for the handicapped for district 87 and a vocational counselor at Courage Center.

At the present time, I am a graduate student in nursing home administration. I have my master's degree in vocational rehabilitation counseling.

I would like to thank you for the opportunity to allow me to testify before you. It is my understanding that this piece of legislation would provide funding for many different facilities and programs for the handicapped.

The coalition is not opposed to this legislation except for the provision which allows funding for the facility known as Vinland Center and as stated before, I will try to summarize in 4 pages what I have here in about 30 pages.

While budgets for services to the handicapped have been cut or kept to below-needed levels of funding, this new proposal for a center which will provide duplicate services is ridiculous.

The moneys proposed for a new center, that is, Vinland Center, could better be put to use in existing programs such as title XIX medical assistance, subsidized housing for the handicapped or accessible transportation for the handicapped.

What Vinland Center proposes for services is not new. These services are already being provided by such local facilities as Courage Center, Sister Kenny, and the Metropolitan Center for Independent Living—and for that matter, the vocational technical schools in Hennepin County.

I ask you, why provide funding for something which is already being provided for? There are other facilities around the country which also provide these same services for their clients and residents.

I know with the cutbacks in medical assistance, they would not provide for services I could receive outside of Minnesota if I can receive them inside of Minnesota. This is true of medical assistance programs in other States.

Generally, they will not pay for services outside the State when they can be found inside the State. The few States which do not provide this type of service proposed by Vinland Center are presently sending their citizens to already existing facilities and programs in more than 37 other neighboring States.

The question remains, If medical assistance will not pay for these services, who will? I contend disabled individuals paying their own way to enjoy services which in most cases can be provided for by facilities in their own States or regions will not go to other areas of the country.

Again, the coalition believes the funding for Vinland Center is funding for duplication of services and that these funds can be put into independent living services for the handicapped which already exist and are used by the handicapped community.

I have attached here testimony which I presented to the State senate here in Minnesota, and I would like to read the summary on these two pieces of testimony. The first one is about medical assistance cuts already in effect, which I read to the State senate in March of 1982.

The Federal Government will decrease by approximately 10 percent the percentage of its matching payment for medical assistance. In Minnesota, the Federal Government will go from paying over 54 cents out of every medical assistance dollar to paying less than 50 percent per dollar.

What does this mean? The cut by 3 percent of the Federal reimbursement rate for optional services in medical assistance will cost Minnesota about $8 million in Federal funding which the State will have to replace in order to maintain services like personal care attendant and physical therapy for the handicapped.

The cuts will also possibly redefine disability for SSI, so that 115,000 people nationally will be made ineligible. In Minnesota, these people will become eligible for general assistance, thereby increasing the cost to the State. With these cuts and proposed cuts, the services provided for the handicapped will be hurt even more than they have been already.

What I am basically saying is that services that are already in place should be maintained and new programs and facilities should not be funded.

I think the moneys can better be spent on existing services.

Thank you. And I am willing to answer any questions.

[Material submitted by Clint Schultz follows:]

PREPARED STATEMENT OF CLINT SCHULTZ, REPRESENTING THE METROPOLITAN HANDICAPPED COALITION, MINNEAPOLIS, MINN.

My name is Clint Schultz and I represent the Metropolitan Handicapped Coalition. MHC is an organization which represents the severely, physically handicapped population in the seven county Metropolitan Area.

I have worked as an Independent Living Specialist for the Metropolitan Center for Independent Living, a Career Counselor for the Handicapped in School District No. 287, Hennepin Area Vo-Tech Schools and a Vocational Counselor at Courage Center. At the present time I am a graduate student in Nursing Home Administration.

I thank you, Mr. Chairman, for allowing me to testify before this gathering today.

It is my understanding that this particular piece of legislation would provide funding for many different facilities and programs for the handicapped. The Coalition is not opposed to this legislation except for the provision which allows funding for the facility known as Vinland Center.

While budgets for services to the handicapped have been cut or at best kept at below needed levels of funding this new proposal for a center which will provide duplicate services is ridiculous! The monies proposed for a "new" center, i.e., Vinland Center, could better be put to use in existing programs such as Title XIX, Medical Assistance; subsidized housing for the handicapped; or accessible transportation for the handicapped.

What Vinland Center proposes for services is not new! These services are already being provided by such local facilities as Courage Center, Sister Kenny and the Metropolitan Center for Independent Living and for that matter the Vo-Tech Schools in Hennepin County. I ask you—why provide funding for something which is already being provided for?

There are other facilities around the country which also provide these same services for their clients and residents. I know with the cut-backs in Medical Assistance they would not pay for services I could receive outside of Minnesota if I can receive them inside of Minnesota. This is true of Medical Assistance Programs in other states. They will not pay for services outside the state when they can be found inside the state. The few states which do not provide the type of services proposed by Vinland Center are presently sending their citizens to already existing facilities and programs in more than 37 other neighboring states.

The question remains: If MA will not pay for these services who will? I cannot picture disabled individuals paying their own way to enjoy services which in most cases can be provided by facilities in their own state or region.

Again, the Coalition believes the funding for Vinland Center is funding for duplication of services and that these funds can be put into independent living services which already exist and are used by the handicapped community.

Why should existing services (See attached testimony given on Medical Assistance and Attendant Care) be slashed by budget cuts and a "new" and duplicate facility be funded when handicapped people are being hurt already!?

Thank you for your time and if you have any questions I will be happy to answer them if I can.

Medical Assistance Cuts

SUMMARY

1. Medical Assistance cuts already in effect. Federal Government will decrease by approximately 10 percent of the percentage of its matching payment for Medical Assistance. In Minnesota, the federal government will go from paying over 54 cents out of every Medical Assistance dollar to paying less than 50 cents per dollar.

2. Cuts proposed for October 1, 1982: a. Redefine "disability" for SSI so that 115,000 people nationally will be made ineligible. In Minnesota, these people will become eligible for General Assistance, thereby increasing the costs to the state; b. Cut by 3 percent the federal reimbursement rate for "optional services" in Medical Assistance. This will cost Minnesota about $8,000,000 in federal funding, which the state will have to replace in order to maintain funding for services like attendant care and physical therapy; and c. A number of changes in various formulas used to compute federal matching funds will result in a loss to the states of more than a billion dollars. These costs will have to be picked up by the states in order to maintain existing benefit levels.

3. New Federalism proposals for October 1, 1983. Federal takeover of Medical Assistance is contemplated. In return, the federal government would turn over to the states the AFDC and food stamp programs.

There is no likelihood that services like attendant care would be included in a federally operated program. If these services were to be retained, it would have to be done by the state with state tax dollars. If the federal program paid for nursing homes while only state money were used for attendant care, there would no longer a financial incentive for the state to pay for attendant care.

Eligibility criteria for Medical Assistance would undoubtedly become more restrictive than they are under existing standards in Minnesota.

Future of Medical Assistance and Attendant Care

This report is being prepared in mid-March, 1982, and is based upon proposals which have been made by the Reagan Administration as of this time.

There are two separate proposals which will influence Medical Assistance. The first is the 1983 budget, which will govern the program for the fiscal year beginning October, 1, 1982. The proposed 1983 budget does have a number of very specific changes which the Administration would like to put into effect later this year. The second proposal is being called "New Federalism." This would completely restructure the existing federal system of providing benefits to low-income people. A number of different ideas are being reviewed and there is no detailed proposal which describes the actual structure which would result from "New Federalism." It is possible to make reasonable comments on problems which would be created by "New Federalism" based upon events which occurred in 1974 when the federal government created SSI (Supplemental Security Income—Title XVI of the Social Security Act) to replace then existing programs assisting elderly, blind and disabled persons.

The 1982 budget proposal will be discussed first. Comments on New Federalism will follow.

I. REAGAN ADMINISTRATION 1983 BUDGET

A. Overview: The federal government is making two general types of proposals. One type would cut benefits to recipients in an attempt to save some money for both state and federal governments. For example, a 16 percent cut in benefits is proposed for Aid to Families with Dependent Children, a program which was already cut 25 percent in 1981.

The second type saves money for the federal government by shifting existing costs to the state. For example, by changing the formulas for federal payments relating to welfare administration, child support enforcement and welfare overpayments, the federal government would reduce its payments to the states by $1,355,000,000 in 1982. While this type of budget cut does not mandate any reduction in benefits to welfare recipients, it imposes new costs upon the states and thus makes it more difficult for the state to finance its own programs for low-income people.

In Minnesota, if all of the Reagan Administration's budget proposals for 1983 were adopted, the state would save approximately $100,000 in state money. However, the cuts in welfare programs caused by the 1983 budget proposals would deprive low-income Minnesotans of over $20,000,000 in benefits. The $100,000 in savings would hardly permit the state to develop its own programs to cushion the impact of $20,000,000 of lost benefits.

B. Factors specific to handicapped persons: 1. Change in definition of disability for SSI.

Under the current law, a person is disabled if he or she is "unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which . . . can be expected to last for a continuous period of not less than twelve months." 42 U.S.C. § 1382c(a)(3). To prove a disability, a person must demonstrate the existence of the impairment by "medically acceptable clinical and laboratory diagnostic techniques." The person must then show that the impairment, when considered in light of "age, education and work experience," would prevent the person from doing any kind of substantial gainful work which exists in the national economy. 42 U.S.C. § 1382c(a)(3).

By changing this definition of disability, the administration proposes to cut off 115,000 people who now receive SSI benefits. The new definition would limit a person's ability to have "age, education and work experience" considered when proving that no work could be performed. Another change would require that the total inability to work lasts for 24 months rather than 12 months.

The impact of this change would be felt most greatly by people who have a substantial impairment combined with limited education and employment skills, for example, mildly retarded persons or uneducated people in their late 50's or early 60's.

Because all of the Minnesota residents terminated from SSI under this change would be unable to perform any work, they would be eligible for state General Assistance payments. Consequently, the SSI cuts would shift some costs to the state.

2. Change in funding for Attendant Care, Home Health Care, Physical Therapy, Medical Equipment and other services.

The Medical Assistance program (Medicaid), is funded by a combination of federal and state money. A law already passed in 1981 will reduce the percentage of federal reimbursement for Medical Assistance costs by about 10 percent over a three-year period. P.L. 97-35 § 2161. In 1981, Minnesota received over 54 cents in federal reimbursement for every dollar spent on Medical Assistance. By 1984, less than 50 cents per dollar spent will be reimbursed. This shifts millions of dollars in costs to the state if the state chooses to maintain its current services.

In addition to the 1981 law already in effect, the Reagan Administration proposes in its 1983 budget to reduce by 3 percent its reimbursement for "optional services" covered by a state Medical Assistance Plan. The federal Medical Assistance law mandates that the states cover five medical services (inpatient hospital, outpatient hospital, lab and x-ray, skilled nursing home, and physician services). There are a dozen additional services which a state may cover if it so chooses. In Minnesota, attendant care, home health care, physical therapy, and medical equipment (wheelchairs) are among the optional services covered by Medical Assistance.

If the 3 percent reduction in federal payments goes into effect, $600,000,000 will be taken from the states that provide optional services. In Minnesota, the loss for 1983 will be approximately $8,000,000. In order to maintain the existing level of services, Minnesota would have to expend eight million dollars which is not currently budgeted for medical assistance.

3. Other Changes: Almost all of the 1983 budget proposals for Medical Assistance are like the 3 percent reduction in reimbursement for optional services in that they cut the amount of federal money being paid to the states without absolutely mandating any change in the state's existing Medical Assistance program. The federal government's outlay for Medical Assistance in the proposed 1983 budget would be reduced by a total of $1,983,000,000. By depriving the states of nearly two billion dollars in matching funds, the 1983 budget proposal creates immense pressure on the states to reduce the current level of medical services for low-income people since

the current service level can be maintained only by expending additional state money.

II. NEW FEDERALISM

The Reagan Administration's "New Federalism Initiative" has two parts. The first involves a simple "swap" in which states would accept full financial responsibility for food stamps and AFDC while the federal government assumed full financial responsibility for Medical Assistance (Medicaid).

The second part of the proposal involves a transfer to the states of 44 programs currently funded by federal grants. The costs of this transfer would be subsidized by a federal trust fund which from 1984 to 1987 would provide federal money to the states during this four-year transition period. There would then be a four-year phase-out of the trust fund (25 percent each year) from 1988 to 1991, at which time no federal subsidy whatsoever would be available for the 44 programs.

Since our main focus here is the future of medical benefits, there will be no discussion of the trust fund and the deletion of 44 federal programs which currently provide benefits to states. The question here concerns the future of medical assistance benefits if the program is taken over by the federal government.

1. Costs and Scope of Benefits: Here are some facts concerning the federal takeover of cash payments to disabled people in January of 1974 when SSI replaced the Aid to Disabled program. (Aid to Disabled had been run like Medical Assistance, i.e., it was administered by state and local governments according to state eligibility standards, but it was subsidized by federal money and had to conform to federal regulations.

The first problem was benefit amount. Minnesota had paid about $210 per month to elderly or disabled persons living alone in 1973. The new federal program which took effect in January 1974 paid only $136 per month.

In order to prevent such a drastic reduction in benefits, the federal law ordered the state to pay a supplement. This supplement was a payment of state money which, when added to the SSI payment of $136, would bring the elderly or disabled person up to the $210 Minnesota level. The supplement, however, had to be paid only to those people who were receiving benefits before 1974. People who became disabled after January 1, 1974, did not have to be paid a supplement.

In 1974, then, Minnesota faced a choice. The state could maintain its higher level of cash payments to elderly or disabled persons who applied for benefits after January 1974, but it would not receive federal reimbursement for these payments. Or the state could refuse to pay any supplement and could save a substantial amount of money by having elderly and disabled Minnesotans rely solely upon the federal SSI payment. Minnesota chose to make the higher payment and continues to do so through the Minnesota Supplemental Aid Program.

It is important to note that in 1974 the state could maintain the same level of benefits only by spending state money. In 1974, when there was a budget surplus, the legislature chose to make the payments.

There is no doubt that a federal takeover of Medical Assistance would follow this same pattern. First, financial eligibility for Medical Assistance would be governed by federal standards. It is reasonable to assume that Minnesota's Medical Assistance standards would be lowered to the SSI eligibility levels. Work incentive provisions adopted in Minnesota during 1979 would probably not survive a federal takeover. Second, benefit levels would be drastically cut. As noted in the discussion of the 1983 budget, the Reagan Administration is already proposing cuts of federal money for "optional services." The 1983 budget message states that funding for these optional services (e.g. attendant care, in-home service, physical therapy) should be reduced "to reflect their lower priority and their discretionary character." Certainly a program like attendant care, which is not now covered by Medical Assistance in most states, stands little or no chance of being covered as a service in a federally operated program.

As in 1974, if Minnesota wished to maintain its current level of services following a federal takeover of a welfare program, it would be required to do it by spending state money. In 1984, however, the federal takeover of one welfare program would be accompanied by a transfer to the state of responsibility for AFDC and food stamp payments. Any financial savings to be realized by Minnesota from the federal Medical Assistance takeover would already be exhausted by the need to fund AFDC and food stamps. In order to maintain existing Medical Assistance services, the state would have to make new expenditures from the state treasury.

2. Local Control and Administrative Costs: When the SSI program began in January, 1974, it shifted administrative responsibilities from the local welfare agencies to

the federal Social Security Administration. However, this did not result in a lowering of administrative costs for the Minnesota welfare agencies. Minnesota was required to keep local staff in order to administer the state supplement for SSI. The state did try to reduce its administrative costs by electing to have the federal agency send out one check that would include both the basic SSI payment and the Minnesota Supplemental Aid payment. After more than a year and a half, the state agency gave up this effort because the federal computer had still not been programed to process accurately the information submitted by the local welfare departments concerning the Minnosota Supplemental Aid payment. Effective October 1, 1975, the local agencies resumed responsibility for sending out checks to elderly, blind and disabled persons, just as they had done prior to SSI's inception in January 1974. We now have two agencies—one federal and one state-administering payments which prior to 1974 had been handled by the state alone.

It should also be noted that in administering SSI, the federal government made approximately one billion dollars in incorrect payments during 1974 and 1975. The amount of money is substantial when one considers that the maximum payment amount during that period was always less than $160 per month.

It is possible that a federal takeover of Medical Assistance would operate more smoothly than the SSI takeover because the federal government already operates one national health program, Medicare. However, in its current form Medicare has little or no experience in administering programs necessary to maintain physicially handicapped individuals in independent living environments.

As is obvious, all local control over the scope and administration of Medical Assistance would be lost if the program were taken over by the federal government.

From the perspective of disabled and elderly people residing in Minnesota, it is fair to say that New Federalism as described by the Reagan Administration has nothing to recommend it. If Minnesota hopes to maintain anything approaching its current level of medical services for elderly, blind and disabled individuals, New Federalism will prove extraordinarily inefficient and cumbersome as a way of administering the services and the added costs to the people of Minnesota will be millions of dollars.

Testimony on the Personal Care Attendant Program

(Presented by Clinton Schultz, Aug. 26, 1982)

Thank you, Madam Chair and members of this sub-committee in allowing me to testify before you on the report. An Analysis of the Department of Public Welfare's Personal Care Attendant Program, and the program in general.

As a recipient of the PCA program I feel I could not live in the community as independently as I do without the assistance of a PCA. Since 1978 I have lived in the community with the assistance of Personal Care Attendants. When the above report came out I found it to be most informative. There was much information in the report that I was not aware of. Thus I must commend the Department of Public Welfare for putting together such an educational report on the Personal Care Attendant Program. While I agree with most of the analysis, I must take issue with the statements about the comparison of the PCA program to skilled nursing facilities.

Comparing the PCA program to skilled nursing facilities is like comparing apples to oranges. If a comparison must be made it should be made between DPW Rule 80 facilities which are "residential facilities for the physically handicapped". The main differences being Rule 80 facilities are reimbursed for unlimited nursing hours, whereas skilled nursing facilities are only reimbursed up to 2.9 hours of nursing care per day.

This would compare to the 6.8 hours of care needed by the sample of 75 people I interviewed over the telephone. Using these 75 people as a sample, I compared their independent living costs with the various forms of institutionalized forms of living (See Graph A).

I asked several questions, the first concerning the monthly income benefits for each individual. Several individuals received two or more income benefits. Forty-seven people received SSDI, thirty-seven people received SSI, three people received MSA, three people were receiving VA, five people were receiving benefits from working and two individuals were receiving other types of benefits. The average benefit received was $376. Three of the individuals that were working received no extra income benefits. In fact, they were contributing an average of $422 towards State, Federal and FICA taxes. Plus they averaged spending down $72 each month toward their Attendant Care costs.

Concerning subsidized housing, only 55 out of 75, or 73%, were living in subsidized living units. The average rent paid by these individuals was $83/month. The average fair market rate of this subsidized housing came out to $324/month for all 75 people. When you deduct the $83 from this rental figure you come up with $241 of government money being spent for this population.

The average number of homemaker/chore service hours was 56 hours per month. This came out to $314/month. This was using $5.61/hour which is paid by the counties to the vendor, which pays for these services to their staff.

When asked where they came from before they entered the PCA program the replies could be broken down into these categories: respiratory center (2), nursing home (4), family (7), Rule 80 facility (60).

When comparing the use of paratransit in the community now versus an institutional setting there was no significant difference. These individuals averaged 8 trips using paratransit while living in an institutional setting compared to 7 trips using paratransit while in the community (monthly basis). Paratransit included the following: Metro Mobility, Med-Cabs and ambulances.

When including the Food Stamp Program, the average benefit came out to $10/month. The reason for this was that 65 percent of these individuals did not receive food stamps. The reasons given for this were 1.) "It was too much of a hassle with the paperwork", 2.) "There are people who are poorer than me who can benefit from the food stamps", 3.) "I really don't need them".

Another question asked was where would individuals go if there was no Attendant Care progam. 55 percent said they would try to go back to a Rule 80 facility, 9 percent said they would try to go back to a nursing home, 4 percent said they would have to go to a respiratory center, 15 percent said they would go back to family or relatives, 17 percent were uncertain.

With this particular sample the average Attendant Care cost per month came out to $945. As stated earlier, based on a 30-day month the average daily hours of care is 6.8 with a cumulative average of 205 hours/month per recipient.

All the nurses were registered nurses who worked on a private basis except for two registered nurses who worked through a health services vendor. These nurses averaged 11½ visits/year, with each visit averaging 1 hour. In monthly terms this comes out to slightly less then 1 visit/month. At an average of $10/hour, the expense to medical assistance is $10/month per person.

There was no significant difference with recipients seeing a physician an average of 6 times/year while living in an institutional setting, and now when they live in a community setting. The average number of visits to a physicians/year is 7 visits while living in the community.

Out of these 75 individuals only 1 individual was receiving physical therapy on a regular basis. At 8 visits/month this comes to $228/month. If this was carried over to the 350 people enrolled in the PCA program, we could project roughly 5 individuals using therapies a cost of roughly $1,140/month.

Perhaps to emphasize the importance of this program we should take a look at a Rule 80 facility which has discharged 240 people from 1976 through 1981. Of the 240 ex-residents, 168 have been surveyed to find out if they still live in the community. 125 of the 168 live independently with the assistance of a PCA. Only 38 individuals live without the assistance of a PCA. The remaining 5 rely on their spouses to provide PCA services. I think it is obvious that these numbers show the need for the PCA program and the success of the program to enable severely physically disabled individuals to live the lifestyle they choose.

The only recommendations I would make to the sub-committee are these: 1.) An 1115 waiver should be applied for and implemented to further improve the PCA program to keep it from being locked into regulations which impede rather than enhance the quality of these services. 2.) While training of a PCA is important to the success of the program, it should remain in the hands of the consumers, for they, and only they, know what their needs are. Formal training of PCAs will not guarantee qualified attendance.

Using the number of 350 recipients in the PCA Program we can compare cost figures. While it is obvious that the cost of a skilled nursing facility remains less than the two main groups found in the PCA Program, SSI and SSDI, there still remains the fact that we are comparing apples to oranges. When we compare oranges to oranges or SSI and SSDI groups to Rule 80 facilities and an "ideal" nursing home where the number of nursing care hours would equal the 6.8 hours found in the sample group we find the PCA Program to be the more cost-effective.

The cost to taxpayers for the 350 people in the PCA Program is roughly $528,504 per month for people on SSDI. For people on SSI the cost is $247,782 per month. The same number of people in a Rule 80 facility would cost the taxpayers $934,500 per month. This is an increase of $158,214 a month for the taxpayers or a yearly cost of $1,898,568 which can be saved if these same people could remain on the PCA Program.

If we use these same figures to compare the cost to the "ideal" nursing home we it would cost the taxpayers $992,250 per month versus the $776,286 per month on the PCA Program. Again the savings to the taxpayer comes to $2,591,568 per year.

Looking at the difference between the nursing home costs versus the PCA costs we find a small difference of $661,500 per month versus $776,286 per month. This comes to a difference of $114,786 per month. This is a difference of $1,377,432 a year.

But while we could argue the cost benefit or non-benefit of the PCA Program the main point I would like to make is this: Nursing homes and other institutional settings are not for the young, active severely disabled adult like myself; independent living in the community with the assistance of a PCA is.

RANGES

MONTHLY INCOME BENEFITS

Range: $28 - $1100 per month. Average: $376/month

MONTHLY RENT

Range: $27 - $179 per month. Average: $83/month

FAIR MARKET RATE

Range: $249 - $629 per month. Average: $324/month

HOUSEKEEPING HOURS

Range: 0 - 92 hours per month. Average: 56 hours/month

PARATRANSIT USE (Community living)

Range: 0 - 50 times per month. Average: 7 trips/month.

PARATRANSIT USE (Institutional living)

Range: 0 - 37 trips per month. Average: 8 trips/month.

FOOD STAMPS

Range: $0 - $70 per month. Average: $10/month.

PCA EARNINGS

Range: $120 - $3720 per month. Average: $945/month.

PCA MONTHLY HOURS

Range: 24 - 744 hours per month. Average: 205 hours/month.

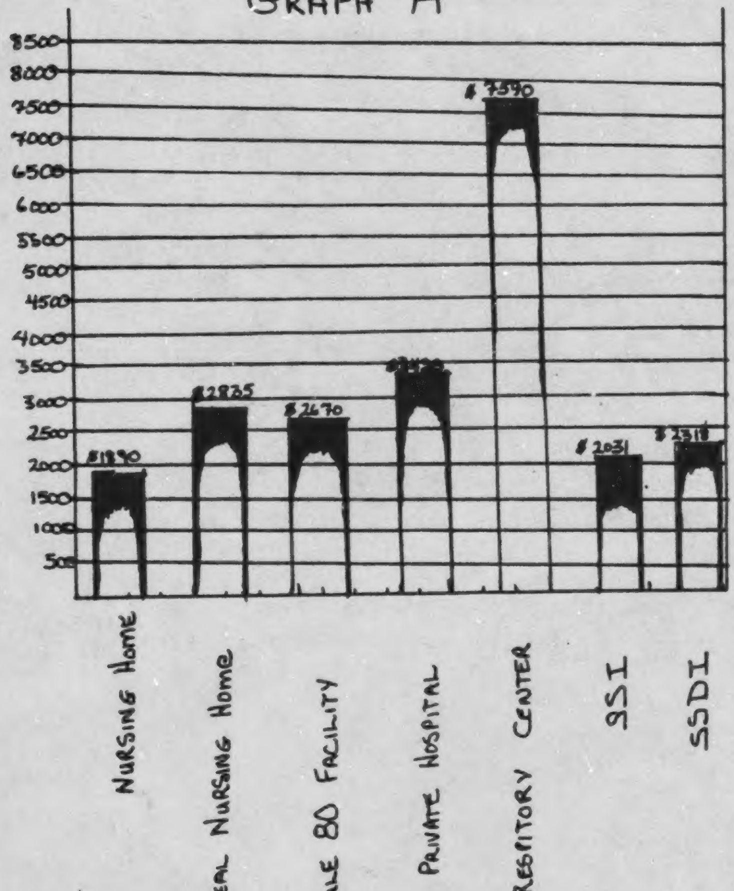
NURSING VISITS

Range: 1/year - 52/year. Average: 11½ visits/year.

NURSING HOURS

Range: ½ hour - 2 hours per visit. Average: 1 hour/visit.

MONTHLY COSTS
GRAPH A



Courage Center 3915 Golden Valley Road • Golden Valley, Minnesota 55422 • (612) 588-0811

July 26, 1982

Mr. Thomas Gaylord
Attendant Care Program
Department of Public Welfare
444 Lafayette Road
First Floor
St. Paul, MN 55101

Dear Mr. Gaylord:

This letter comes as a response to a memo dated May 12, 1982, from the Commissioner of Public Welfare. It was attached to the study conducted by the Office of Policy Analysis regarding the Personal Care Attendant Program. Since your office administers this program, I am directing my comments and concerns about the recent changes to you.

I wholly concur with the conclusion of the study that the PCA program has "provided clients with physical disabilities the opportunity to live in the community rather than an institutional setting." All of the other areas that contribute to independent living such as housing, transportation and employment would not be effective without the support of the PCA program.

The ability of many individuals to maintain all components of independent living is essential to surviving in the community. Although the changes in the reimbursement mechanism for the PCA program were probably made to assure and promote its solvency, I do feel it could jeopardize the ability of many individuals to retain attendants. If this is the case, many of these individuals will be required to return to institutions or their families and return to a dependent role emotionally, socially and financially. Certainly, increasing anyone's dependency speaks not only to their own quality of life, but also to the loss that society incurs when an individual's self-sufficiency is lost.

As the administrator of a program that has many former clients utilizing the PCA program, I certainly appreciate how difficult it must be to manage a program with the rapid growth it has experienced. If our staff can be of assistance in providing further feedback about the impact of recent changes, please do not hesitate to contact me.

Sincerely,

Jan Hart

Jan Hart
Administrator
COURAGE RESIDENCE

cc Arthur E. Noot, Commissioner of Public Welfare

Jim Ramstad, State Senator

Comprehensive Services
for Disabled Citizens, Inc.
[illegible] AVENUE SOUTH
MINNEAPOLIS, MINNESOTA 55406
(612) 721-6173

July 13, 1982

Commissioner Arthur E. Noot
Department of Public Welfare
Fourth Floor
Centennial Office Building
St. Paul, MN 55155

Dear Sir:

This letter is in response to revisions in the personal care program procedures issued by your office May [illegible], 1982. It is unfortunate that responses to the study these changes are based on and responses to these revisions were not sought from concerned parties outside the Department of Public Welfare prior to the issuance of the revisions. It is disturbing to me that prior responses were not solicited from our agency since we have a better understanding of the practical working realities of the personal care program than anyone else in the state. This arbitrary and seemingly less than open method of making changes in programs adds to the public perception that governmental agencies are untrustworthy and unresponsive to human needs.

I am enclosing a written response to the study of the personal care program and the revisions in the program procedures. I or other members of our staff would welcome an opportunity to personally discuss these matters with you.

Sincerely,

Wayne Labar
Service/Administration Assistant

Enclosure

RESPONSE TO THE PERSONAL CARE PROGRAM STUDY AND CHANGES

The study and subsequent changes addressed four major concerns. They were (1) rapid program growth, (2) procedural problems, (3) cost effectiveness and (4) quality of care.

This program, like all new programs, initially grew very rapidly, but comparative rates of growth in percentage terms indicated a rapidly declining rate of growth thereafter. Falling from a 141% rate between July 1978 and February 1979 to a low of 3% between October 1981 and January 1982. In actual numbers served, this program serves an insignificantly small population, as compared to the total population of disabled persons in Minnesota or total recipients of Medical Assistance.

Most of the procedural problems are a result of administrative failures. Medical Assistance has few, if any, administrative guidelines for this program. It has inconsistently applied its policies, and in some cases totally failed to follow its own rules.

The report indicates that the personal care program is not cost effective. This is true if one compares its costs to those of skilled nursing facilities when the social costs of personal care program are added, but such a comparison is inequitable. According to the sample of client hours of service and payments made as indicated in the study, the average client requires in excess of six hours of 'hands on' care per day. This is two to three times as many hours of care as skilled nursing facilities are required to provide and are able to provide. Rule 30 facilities are probably better able to provide care closer to six hours per day. A fair comparison from an accounting standpoint would require comparing attendant care plus social costs to either Rule 30 facilities or to multiplied skilled nursing facilities costs by a factor of two or three. On this basis the personal care program would be cost effective.

The issue of quality of care is totally unsupported in this study. The study cites it as an issue as does Commissioner Noot's cover letter. This by itself is meaningless. There is no indication what the quality of care now is, if it is adequate or inadequate, how it compares to the quality of care under alternative methods of providing care or if the changes will improve or undermine the current quality of care under the personal care program.

In conclusion, it appears that the study is seriously flawed and that recommendations based on it to be built on quicksand. The recommended changes appear to further complciate an already complicated program. The requirement that attendants must be trained is the most destructive. It further hampers the ability of competent disabled persons to secure caregivers and thereby undermines the purpose of the program. The Department of Public Welfare apparently fails to understand what independent living is and how the personal care program effects it. The Department of Public Welfare and the recipients of this program would be both better served by

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looking at some unaddressed issues such as: (1) what kinds of persons should this program serve, (2) who is competent to train attendants, (3) how can recipients and administrators work together to improve the program, (4) would some disabled persons be better served under alternative delivery methods, and (5) what should the respective roles of the recipient, attendant, and payment source really be.

If the Department of Public Welfare is really committed to servicing the needs of physically disabled persons and enhancing their opportunities to live independently, it would take a more critical look at the problems of the personal care program before proceeding and would consult more carefully with the persons most directly affected by the program, the recipients themselves.

Wayne LaBar, Administrative Assistant
Comprehensive Services for Disabled Citizens
June [illegible], 1977

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Mr. Arthur E. Noot
Commissioner of Public Welfare
Department of Public Welfare
Centennial Office Building
4th Floor
St. Paul, Minnesota 55155

Dear Commissioner Noot:

I have just had opportunity to review the Personal Care Attendant Program Study and I would like to express my concern and that of Courage Center's relative to some of the recommendations. We currently have one of the most outstanding independent living programs in the United States in operation here at Courage Center and people from all over the United States and foreign countries visit Courage Center to find out how it works in this community and why. The reason it works effectively here is because of the concern, contribution and cooperation of many different individuals and organizations. One of the key elements is an excellent Attendant Care Program enabling many severely handicapped individuals to be a part of, rather than kept apart from, the community.

While I firmly believe that it is a requirement of responsible stewardship of public funds that we be as economical as we can, I am convinced that the Attendant Care Program is less expensive and a much more human approach to the needs of our severely disabled citizens than a simple conclusion that it would be cheaper to care for them in nursing homes. I do hope that your department will carefully evaluate all aspects of independent living and that before any definite conclusions or changes are made, organizations like Courage Center and the hundreds of disabled people we've helped to a more full and independent life will get an opportunity to give some input.

While I commend you for the study, I think some of its conclusions are not very carefully thought through or documented.

Very sincerely yours,

W. B. Schoenbohm
Executive Director

WBS/klk

Mr. Arthur E. Noot
Commissioner of Public Welfare
Department of Public Welfare
Centennial Office Building - 4th Floor
St. Paul, Minnesota 55155

Dear Mr. Noot:

I am in receipt of the Personal Care Attendant Program Study. I commend the Department for initiating a study of the Personal Care Attendant Program and assessing it's strengths and weaknesses. I have reviewed the study and have a number of comments that I believe important and appropriate. I have had considerable involvement with the Personal Care Attendant Program and have had ample opportunity to understand it's positive and negative attributes.

I am presently the Executive Director of Accessible Space, Inc., the only corporate vendor operating within the Personal Care Attendant Program. Prior to starting Accessible Space, Inc., I had direct experience as a personal care attendant in the home of a disabled individual. Although I will be leaving Accessible Space, Inc. to attend the Harvard Business School, before leaving I would like to address this study and make recommendations regarding future operations of the program.

1. *The study provides an appropriate analysis of program utilization and composition. However, certain sections of the study appear to make quantum leaps from available data to final conclusions. The section regarding Accessible Space, Inc. was particularly alarming. The author states that there are "apparent savings" with Accessible Space, Inc. However, the study states that vendor providers are "likely" to be more expensive than individual providers. I find it hard to believe that anyone, with knowledge of A.S.I.'s operations and the negotiated contract, would make those statements. A.S.I. has conclusively shown that it is a more cost-effective alternative to both the existing providers under the Attendant Care Program and existing providers of institutional care. With no data to back up this subjective conclusion, I strongly feel these references should be deleted from the study.*

2. *The authors also believe that there is a lesser degree of contact and knowledge of the direct care situation within A.S.I. than with individual personal care providers. Again, having spent no time evaluating the A.S.I. operations, I find it hard to believe that*

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the authors could make this judgment. In fact, A.S.I. is mandated by Hennepin County, Ramsey County and the Department of Housing and Urban Development to maintain open records and provide disclosure to any interested parties. I would suggest that it is a great deal easier to evaluate the quality of services, approach to provision of services, and financial operations within A.S.I. than with any individual providers under the program.

I will not comment any more on the section regarding Accessible Space, Inc. except to say that I believe it was written without any analysis of our actual operations. This is a very considerable flaw for a study that could have wide-ranging impact on the future of the Personal Care Attendant Program.

3. *From a broader perspective, the study suggests that the Personal Care Program is actually more expensive than institutional care. The authors of the study believe that comparisons with DPW Rule 80 facilities are inaccurate and inappropriate. The authors believe that, in line with program requirements, DPW Rule 80 facilities are for short-term stays. In reality, I can assure you this is not usually the case. It would be very useful for the Department to evaluate the length of stay at the Courage Center, Trevilla of Robbinsdale, and all other DPW Rule 80 facilities. I believe such a study will conclusively show that the length of stay within DPW Rule 80 facilities is substantially longer than what the guesswork of this study would indicate.*

Also, the authors believe that the Personal Care Attendant Program should be compared with skilled nursing facility costs for comparative purposes. Such an approach fails to draw on the information found earlier in the study regarding the user population. Most individuals enrolled under the Attendant Care Program have severe physical handicaps, and most are relatively young (20-35 years old). These individuals are typically in the more expensive institutional settings because of their care requirements. In addition, most, if not all program participants are in the metropolitan areas, where institutional costs would be higher. To use statewide averages for SNF costs as an accurate comparison obviously skews the findings. A typical resident within a skilled nursing facility requires a substantially lower amount of care services than the typical recipient under the Personal Care Attendant Program. Therefore, the conclusions regarding the cost comparisons of the Personal Care Attendant Program to institutional care should be disregarded because of such reckless data comparisons.

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4. *In the same section of the report, the authors suggest that when Personal Care Attendant services and Chore/Homemaker Services reimbursed by the counties are viewed together, the expenditure for those two services "can be" $50 per client per day. This is not even close to the average actual combined revenue for a typical recipient. I suggest that the authors of the study do a more in-depth review of the amount of funding being provided by the counties for homemaker/chore services. It will obviously be a surprise to them to learn the actual reimbursement amounts.*

5. *It is extremely fortunate that, in spite of the study's flawed quantitative perspective, quality of care and quality of life were given some consideration. The Program offers the opportunity for independence for handicapped individuals who would otherwise be forced to reside in institutional settings. Even if it was more expensive, such an opportunity would be worth the added costs, over the long-term, for public agencies. Broadened opportunities for independent living will slowly decrease the level of dependence upon public assistance. This model has been shown to be true in other welfare activities, as I'm sure you are aware.*

6. *We were also happy to see the training requirements included in the study's recommendations. Accessible Space, Inc. operates a comprehensive training/evaluation program. I believe it would be appropriate for the individuals responsible for administering this program to visit with members of our staff. Our training program covers all facets of the Personal Care Attendant role and could be easily duplicated. We would be very happy to share this program with the State and assist the State in developing appropriate training guidelines.*

7. *The study closed with the statement that "the Personal Care Attendant Program is an extremely expensive program for the State". I strongly disagree with this conclusion. The supporting data within the study does not lead to that conclusion and it appears to be more a function of the author's bias than objective analysis. I strongly urge you to assemble more data regarding cost economies and instruct the study authors to make conclusions based on actual information. Comparing per diem costs is extremely misleading. The ancilary service usage within an institution by a recipient of welfare services is substantial and will completely skew the very surface analysis done in this study. I hope your staff can find the time to conduct this more thorough analysis.*

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In closing, I am very supportive of your efforts to examine the Personal Care Attendant Program. It is a program that sets Minnesota apart from other states in the provision of humane, cost-effective alternatives to institutional care. It has become a nationwide model that other states will increasingly look to for guidance and example.

Thank you very much for the opportunity to address the study.

Best regards,

Stephen F. Wiggins
Executive Director
Accessible Space, Inc.

SFW:alc

cc: Thomas Gaylord, Director, Medical Assistance Division, DPW
Robert Baird, Assistant Commissioner of Public Welfare
Darcy Miner, Office of the Governor
Pat Gaylord, Office of Policy Analysis, DPW

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HOUSING
TRANSPORTATION
ATTENDANT CARE
GROUP SUPPORT
REAL

244 West Main • Marshall, Minnesota 56258 • Phone (507) 532-2221 (Voice or T.D.D.)

August 23, 1982

Clint Schultz
2609 Blaisdell Avenue South #206
Minneapolis, Minnosota 55408

Dear Mr. Schultz,

As I related to you in our telephone conversation I have not found anyone living in this area utilizing the Attendant Care Program paid through Medical Assistance. The people that could use this program are getting their personal care needs met through spouses or other relatives (and therefore ineligible) worker's compensation, or by paying out of their pocket because their income or resources exceed the MA quidelines. Many people in this area that could be living independently with the assistance of a PCA are still living in nursing homes. This is due to choice as well as to lack of knowledge of the program.

Good luck at the Senate hearings, please remind them that this is a quality of life issue not just an economic or quality of care issue. Also that DPW's recommendations of more reporting by nurses, social workers and physicians is very expensive in time, wages and transportation costs, adding to the cost of the program.

Next month students will return to Southwest State University many with PCA's. Should you need more statistics at a later time (there is always round two) please let me know and I will get information from students and their friends.

Sincerely yours,

Barbara Wall

Barbara Wall
Consumer Outreach Specialist/Counselor

BW:ls

Mr. **Erdahl**. Thank you very much, Mr. Schultz. I think what we will do is to hear from the other members of the panel, and then perhaps we will have some questions, and at least there is a possibility that my colleague will be able to get here by then.

So why don't we go ahead? Who wishes to proceed next?

STATEMENT OF JOYCE VINCENT, PRIVATE CITIZEN

Ms. **Vincent**. I will, if you like. My name is Joyce Vincent. I appear here as a private citizen. I happen to work at Courage Center in an area not related to service programs, and I don't agree with the official position in the past of the Courage Center board of directors, and I feel that I must speak as a person with a disability who cares about quality and needed programs for the disabled.

As Clint pointed out, there are many programs right now whose funding is jeopardized and which have already been cut. It makes no sense to start a new program that is in essence not needed, especially not the physical plant proposed for the center.

I don't have any quarrel with three parts of the bill before you, and I feel that tacking on the Vinland Center is an unwise move which could jeopardize the other parts of the bill or possibly, because the others are worthy programs, give more weight and credence to the Vinland Center than it deserves.

The physical plant that Vinland is proposing is a Taj Mahal. It is a Sons of Norway ego trip, as I define it, because it is largely based on the Bietostolen model from Norway, which may be fine for a small country like Norway, where there weren't the kinds of services in all the communities as there are throughout the United States.

The center there really does not parallel in the kind of service that should or could be provided here in the United States. The physical plant, including the horseback riding, the pool, gymnasium and all the other facilities already exist in many areas throughout the United States. Here in Minnesota we have multimillion-dollar facilities at Camp Courage and Courage North.

There are programs in healthsports, and recreation operating out of Courage Center, the Sister Kenny Institute and other programs. That is just in this area. And there are programs throughout the United States in many kinds of communities.

There are, of course, needs for more programs in more communities, but what the need is for is the dissemination of knowledge of how to set up and use such programs in the communities and not additional physical plants in an area where there are more than enough.

The question of bringing people to a national center is one that poses problems, too. As Clint pointed out, who is going to pay for that? If a person is disabled and is on a per diem or in an institution, that is jeopardized by going out of State.

There is no groundswell of demand or desire for this particular facility on behalf of the handicapped population. I think if you put it on a list of all the things that are needed, including such things as transportation, attendant care, housing, job training, jobs, educational services, and independent living services, learning how to cope with the disability and managing in the community and in the home, you would find that a new physical plant for health sports would rank just about at the bottom.

With limited funds available, I think it would be a crime, a real shame to try to spend that kind of money for something that is such low priority for the needs of the handicapped. The State of Minnesota gave, or let's say, basically appropriated, with the establishment of a certificate of need, some $200,000 for Vinland Center.

The certificate of need has not been obtained. There shouldn't be any Federal funds spent on a facility such as this that is untried and basically unneeded without the establishment of a real need and priority with all the other programs that are needed by the disabled.

The cost-effectiveness is questionable, too. I think that bringing people from throughout the country to a so-called national center is not as effective as providing the services in the home community. The detailed experience, expertise, program development in the whole area of health sports, wellness, recreation, has been going on for years throughout the country and here in Minnesota, as I mentioned, at Sister Kenny and Courage Center.

The other communities that need such guidance, let's say, on development of their own programs, could well obtain it through the agencies and organizations that already exist and which are equipped and prepared to share that knowledge.

Courage Center has developed and is seeking private funding for the Courage Center Independent Living Institute, which would share the expertise that has been developed over the years, and the whole range of physical restoration services, healthsports, recreation, independent living, employment—the whole range of services needed by the disabled.

And that is what makes sense, the sharing of the knowledge that already exists for the proposed Vinland Center. To build a multimillion-dollar facility utilizing taxpayers' funds is a crime. That is a shame. And the limited funding that is available should not be wasted on something like that. The sharing of knowledge makes sense. That knowledge already exists, it can be shared through vehicles that already exist, and for a program such as the institute that Courage Center is proposing.

Also, the whole concept of Vinland has been one that has been developed from the top down, not from the grass roots up. There were some individuals who had perhaps some private, hidden agendas in terms of their Norwegian heritage or their particular concept of healthsports as related to the physically handicapped.

There is something about the thing that to me smacks of paternalism and exploitativeness toward the disabled. The programs have not been developed from what the needs are in the United States.

They have been taking a model that was used in Norway and trying to work it into a situation in the United States. It doesn't really make sense. It probably would be, at best, a regional center, and not a national center, and the whole range of physical plant that is proposed is already in existence in this region, and it isn't needed.

Those basically are my comments on the matter right now.

Mr. Erdahl. Thank you very much.

[Letter from Joyce Vincent follows:]

MINNEAPOLIS, MINN., *September 13, 1982.*

Hon. AUSTIN J. MURPHY,
Chairman, House Subcommittee on Select Education,
House Office Building, Washington, D.C.

DEAR MR. MURPHY: I would like to summarize the comments I presented in person at the September 2, 1982 hearing in St. Paul, Minnesota regarding the Handicapped Individuals Services Training Act (H.F. 6820).

Three of the four programs designated for funding under this Bill are those which deal with services for the hearing impaired and blind. These services are worthy of support and deserve the proposed funding. They are established, reputable and needed programs.

However, a fourth part of the Bill is the Vinland National Center. Funding for this new and untried venture has been attached to the other established programs as a tactic in obtaining funding. Vinland does not deserve Federal funding. There simply is no need for the proposed multi-million dollar Vinland physical plant for healthsports for the handicapped in Loretto, Minnesota.

As a person who is handicapped and who uses a wheelchair on my job at Courage Center, where I work in a nonprogram area, I am familiar with programs for the handicapped in the area of healthsports, both in Minnesota, the upper Midwest region and throughout the country. There are many well established and well developed programs in healthsports for the handicapped in this country, perhaps one of the foremost at Courage Center. There are many communities, of course, which do not have such programs. What is needed is simply the sharing of knowledge of how to develop such programs in other communities, not another physical plant for healthsports. Minnesota already has several extensive facilities and programs in the area of health sports, at Courage Center, at Camp Courage, at Courage North, at the Sister Kenny Institute, to name a few. As a matter of fact, two facilities—Camp Courage and Courage Center—are complete with swimming pools and gymnasiums, as well as living accommodations and classrooms. These are similar to the facilities which Vinland proposes. Both of them are located within 25 miles of the site where Vinland proposes to build its multi-million dollar facility. It is simply ridiculous to spend Federal dollars to build another similar center at the proposed site.

Even if building the Vinland healthsports center were necessary for sharing information about how to conduct healthsports programs, it simply would not be wise or necessary to build it in a state that already has such facilities in far greater numbers than other states. It would make more sense to build it in a state that is service poor where it would not largely duplicate existing facilities.

If the Federal government is going to get into the business of providing healthsports facilities for the handicapped, it should perhaps look at the effective use of the money. It may well be far better to upgrade some of the very fine facilities for the handicapped which already exist in some states so that regional healthsports centers could be provided for the handicapped. There are fine camping facilities for the handicapped which have pools at Hemlocks Outdoor Education Center, near Hartford, Connecticut; at Camp Ascca in Alabama; at Camp Wawbeek in Wisconsin, at Camp Sunnyside in Iowa; and at Bradford Woods in Indiana. Many of these camps would be delighted to have some additional funding to upgrade their campuses with a gymnasium if they don't already have one and to have funding provided for programs that could be carried on the eight months of the year that they are not engaged in camping.

If the Federal Government is going to provide funding for healthsports programs, it would perhaps be a good idea to take a look at where the existing extensive expertise already is in the area of healthsports. One of the finest and most extensive programs already exists at Courage Center. Another one is at the University of Indiana. With far less expenditure of money for staff and physical plant, healthsports expertise could be exported from facilities such as these to other parts of the country. What makes more sense is to share the knowledge of sports and recreation for the handicapped so that programs can operate in local communities, rather than to build another multimillion dollar physical plant in a location where such physical facilities already exist.

The need for the Vinland Center has not been established. Their original survey back in 1977 showed considerable lack of interest and support from rehabilitation agencies and other organizations. At present the program is opposed by organizations such as the Metropolitan Handicapped Coalition. Its program and methodology has been questioned by the Minnesota State Council for the Handicapped. The Certificate of Need for the program has never been obtained from the State of Minnesota, although this was a mandate of the legislature when it allocated a matching $200,000 for the gift from Norway in 1977.

Before the Federal Government starts funding new programs such as Vinland, it should make sure that the need is clearly established. It should make sure that the services and the facilities do not duplicate existing programs. The Vinland supporters are fond of saying that their program extends beyond the traditional healthsports for the handicapped. However, their program is far from unique, and much of the program that they are proposing is already being accomplished.

In a time when Federal funds are being cut-back for many really needed programs for the disabled, I think it is a serious error to provide Federal funds for a new program that has very low priority among the handicapped community. I venture to say that if you survey today the entire handicapped population of the United States as to the need for a new healthsports center for the handicapped, you would find that it ranks right at the bottom. Of far greater need are well established programs that foster independent living in the areas of transportation, housing, attendant care, medical assistance, education and job training. Unfortunately, all of these essential existing programs are being cut. Medical assistance which provides attendant care has been cut by 10 percent. Funding for transportation services has been reduced. Subsidized housing, on which disabled people depend, is being cut $60 billion. Supplemental security income (Aid to the Disabled) has reduced benefits and cut 80,000 disabled individuals. Vocational education which helps disabled people get jobs has been cut $148 million.

To me, it is a crime and a shame to cut the essential services for the handicapped and spend precious Federal dollars on an unneeded healthsports center for the handicapped.

The cost efficiency, the methodology and some of the content of the Vinland program really need to be seriously looked at. There are serious questions about the funding for such a center on-going. Medical Assistance in many states will not pay for a handicapped individual to obtain services out of the state which the individual can get inside the state. Many handicapped individuals would find the cost and distance of travel to be prohibitive, as well as find it difficult to get time off their jobs to go to a national center for healthsports.

The question of private funding for such a center should be looked at before the Federal goverment builds a healthsports center that would possibly erode the same sources of support for other existing similar programs in the state of Minnesota. The United Ways, the foundations, businesses, fraternal organizations and individuals are already cutting back their support for existing agencies. To add another service for the handicapped in an area which already has many, could pose serious funding problems for existing, well-operated programs for the handicapped.

The very basis for the Vinland proposal is one that is questionable. The Beitostolen healthsports center in Norway on which the Vinland Center is patterned, serves a small country, about the size of Minnesota. It simply does not carry over that a similar center would properly provide direct service to handicapped individuals on a national basis in the United States. The Vinland concept got its impetus from some Norwegian Americans who pursuaded the government of Norway to designate its $200,000 Bicentennial gift to the United States for a healthsports center in Minnesota. While such a gift is very nice, I question that federally funded programs and facilities should be based on a gift from a foreign government.

There has not been a current assessment of the need for programs and facilities for healthsports for the handicapped. I think if you would conduct such a survey of programs throughout the country, you would find that the Vinland Center simply is not needed. One must distinguish between the physical plant and the program in healthsports and recreation for the handicapped. The physical plant in Minnesota is simply not needed. It would be far better to utilize facilities that already exist in YW & YMCA's, public schools, recreation centers in communities throughout the United States, so that the handicapped can participate in their own communities and states in healthsports and recreation programs. The programs, that is the expertise in how to conduct such programs for people with differing disabilities, is already well developed and established in many programs, such as at Courage Center and the Sister Kenny Institute and programs in Indiana and elswhere. Such expertise can be shared with the rest of the country without building a physical plant.

As a matter of fact, Courage Center is establishing the Courage Center Independent Living Institute, which would share with the rest of the country the well developed programs in independent living and healthsports for the handicapped with the rest of the United States and the world. Many visitors from around the country and the world already come to Courage Center to obtain information on how to establish programs in their own community. Courage Center has been seeking private funding for developing and expanding the Institute. I would propose that the $500,000 that Courage Center is seeking to establish the Independent Living Institute would be a far better expenditure for federal funds. With one-tenth of the expenditure, the people of the United States would be getting twenty times the value in healthsports for the handicapped as well as training in all other aspects of independent living for the handicapped.

Before any further funding goes to Vinland I think it would be enlightening to have a federal audit of how they have spent the $1.8 million federal funds they have received so far to conduct some programs. How much money have members of their Board of Directors received for consulting fees? How cost-effective have their programs been? What is the cost-per-participant as compared with other organizations? How much money has been spent on travel, fundraising and promotion of this Taj Mahal, which is basically a Sons of Norway ego-trip?

In summary, I strongly urge that the Vinland National Center portion of H.R. 6820 be deleted. The funding for the Vinland National Center should stand on its own merits and should not ride along on the coattails of other well established and deserving programs.

The Vinland National Center simply is not needed. Don't waste federal dollars on it. Take a good look at what exists today in the area of healthsports for the handicapped. There are far more cost effective ways that healthsports programs for the handicapped can be helped in this country.

Very sincerely yours,

JOYCE VINCENT.

Mr. **ERDAHL**. I am sure that some people have questions. I know we will have some testimony out at the Vinland Center this afternoon, and I think rather than take time for rebuttal here, the people will have an opportunity to respond then if they wish.

Next on our witness list is Dr. Dorothy Peters. Please proceed.

STATEMENT OF DOROTHY PETERS, PRIVATE CONSULTANT, COURAGE CENTER

Dr. **PETERS**. Thank you.

I am Dr. Dorothy Peters, and I am a special consultant on independent living. I am not a member of the staff at Courage Center. I am a private consultant on retainer.

Long experience in special education and rehabilitation, my doctorate is in educational psychology, which, I believe, is one of the best possible approaches in terms of practicality and common sense to anyone who has problems, many of which our temporarily able-bodied friends have, the same as those of us with disabilities.

So we try to use the common sense approach. In this particular session we would like to use the common sense approach to some questions.

No. 1, the same body that has been appropriating Federal funds makes the recommendations for appropriations for Federal budgets and will also be appropriating funds for duplication.

It has already been mentioned, cuts in Federal funds which are going to affect local communites and those of all handicapped and disabled peoples of all kinds across the board and in all ages.

In other words, we cut the budget on one hand for these services. Mr. Erdahl, did you vote for the 1982 budget, yes or no?

Mr. **ERDAHL**. Yes.

Dr. **PETERS**. You voted yes. So in fact then, you helped cut——

Mr. **ERDAHL**. I am not going to get into a political argument.

Dr. **PETERS**. I am not making a political argument.

Mr. **ERDAHL**. You asked me a question. I am not a lawyer, I am a farmer. One of my lawyer friends said don't answer questions yes or no. I was very involved in maintaining many of the programs that the handicapped need and now have, and we can get other people to testify to that.

I would rather you would stick with your testimony. You can make any comments you wish.

Dr. **Peters**. I am not a lawyer, either.

Mr. **Erdahl**. We both have that advantage, then. Please proceed.

Dr. **Peters**. Right. In that same connection, the matching funds that I understand from the bill which will be required of Vinland for the Federal appropriations will, of course, have to come from the same private sources, which the private sector has provided funds for years to rehabilitation facilities in this country.

That means that at the same time that the Federal Government is funding a part of the program, a very large part of it to be the construction program of about $10 million, I have seen the Pierman Associates report which shows the budget for capital construction, and this seems to me to be an unnecessary expenditure of that large amount of funds in an area, particularly Minnesota, which has an outstanding reputation for its service to the disabled.

I have traveled this country widely. I have worked in large sections of the country. I have worked with disabled veterans and also with active servicemen during World War II in military hospitals, and I will have to say for Minnesota, I am proud to be one.

I have only been here 16 months, but I am proud of it, and that is one of the most particular reasons for being very proud of it, and it is also one of the reasons why I have come in and out of Minneapolis for years to see the kind of things that are happening in this area.

And that is spoken with all sincerity. But I am concerned about the fact that the private foundations, for instance, of Minnesota, in the Twin Cities area, who have been very generous with all rehabilitation facilities, are again going to be asked for funds which from their sources are being eroded and which are being swarmed over literally, with requests for funds at this time.

I have a feeling that the introduction of the Vinland Center in this bill with the other parts of the bill, of which I approve highly—not the inclusion of Vinland Center with the others, but I approve of the three others highly. They have established track records. They have already been line items on the Department of Education for some time, as far as funding is concerned.

I understand that the Keller Institute for Blind and Deaf will now go on a perpetual or permanent type of funding. I have no quarrel with that. Certainly, the Vocational Technical Institute here has done an excellent job and will continue to do so.

I would certainly support the funding of the regional centers for postsecondary deaf and blind education. I have spent a great deal of time as a principal and director of special education of postsecondary and secondary schools, and this is probably one of the most serious needs that we have.

However, I do not feel that the Vinland Center should be tacked on to that coattail which would perhaps one day become a federally funded thing entirely and has not proven in the first place the need and second, has not proven a track record as of this date.

The Pierman Associates report mentions many issues which Vinland will have to deal in its next 10 years, but the one thing that does say positively is that the center particularly has an exceptionally good political network, and I am all for political networks, but not to the disadvantage of others.

If we must work through the political network, that is fine, and we can all learn to do that, but it should not become a political item, and I have definite fears that it could possibly be that. May I just say in summary, basically we would like to ask another question, Is the service for which Government support is being requested intended exclusively for the physically disabled population or is it intended to serve an able-bodied population as well?

If I may point to the last newsletter of the Vinland Center, if you look at the two inside pages of the four, there is a description of the courses which will be offered, I believe it is in the next quarter, and the introduction to both of those sets of dates and courses very clearly says for the physically disabled and able-bodied.

I wonder if those agencies such as the YMCA, those private sector spas, exercise clinics, a lot of other things, compulsivity clinic—that is the newest one—I am very much interested in that—are going to wonder if their business as private business people will also be eroded by support of programs such as this?

Thank you very much, Mr. Chairman.

[Letter from Dorothy Peters follows:]

To: Members of Congress of the United States
House of Representatives
Committee on Education and Labor
Subcommittee on Select Education
RE: H.R. 6820 "The Handicapped Individuals Services and Training Act"
FROM: Dorothy M. Peters, Ed. D.
DATE: 17 Sept. 1982

This letter is to convey to you my concerns regarding the bill cited above. These concerns are basically those extemporaneously expressed at the September 2, 1982 morning public hearing held at the Technical - Vocational Institute in St. Paul, Mn., conducted by Congressman Arlen Erdahl.

As you are aware, the bill proposes appropriations for the Helen Keller National Center for Deaf-Blind Youths and Adults, four Regional Postsecondary Educational Programs for the Deaf (including one at the St. Paul Technical-Vocational Institute), Captioned Films and Related Services for the Deaf, and 5.3 million dollars for Vinland National Center for Healthsports and Physical Fitness for Handicapped Individuals at Loretto, Minnesota.

First, I do not question the appropriations for the already existing blind and deaf programs, all of which have good "track records" and, as is well known, have actually been federally funded for some time. This bill seeks to formalize and continue that process in an orderly way and more timely schedule.

Second, I do, however, raise a serious question as to the $5.3 million proposed for construction and program for Vinland National Center, a relatively new and relatively "untried" operation.

Third, in this time of budget restraints and federal cutbacks in so many programs essential to the seriously disabled particularly, such as transportation, housing, vocational training and rehabilitation, employment, income maintenance and medical care, it appears to be unwise and inappropriate to spend $5.3 million on a facility and program which are viewed by many disabled persons as a low-priority. If that kind of money is to be spent why not use it and other funds to restore some of the budget cuts to existing programs rather than placing a new expense on the taxpayer?

Fourth, the Vinland effort appears to be duplicative at least in the Minnesota regional area where Sister Kenny Institute, Courage Center, University of Minnesota hospital and rehabilitation facilities, Mayo Clinic and many other smaller agencies offer much the same as Vinland proposes _plus_ a great deal more and with a majority of these agencies' financial support coming from private funding.

Fifth, since Vinland Center is designating itself as a "national" center it is hoping to, and apparently has, by-passed the requirement of going through and receiving from the appropriate regulatory channels a "certificate of need" which has been required of all Minnesota agencies + other states.

Sixth, according to the federal funding proposal, Vinland will be required to go to the private sector for matching funds at least until 1989 when it will presumably become "self-sustaining." This is the _same_ private sector which has made practically all of the non-profit private rehabilitation facilities and programs possible over many years and, although being aware of the _needs_ being increased by the present fiscal economies, are now being overwhelmed by requests for funding.

Seventh, the 1983 budget cuts, together with the current continuing "deregulatory" efforts, have pretty well emasculated Sections 503 and 504 of the 1973 Rehabilitation Act and Amendments and the 1975 Education for All Handicapped Children Act (P.L. 94-142), both of which were previously regarded as probably the most important milestones of our history in terms of assurances of basic rights for persons with disabilities.

Eighth, reference is made to the inside two pages of the latest "Vin-line" publication for Fourth Quarter, 1982, paragraph headed "Healthsports Courses which indicates "The Two, Three and Four-Week Sessions offer *disabled* and *able-bodied* persons..." (underlining the writer) and under heading "One-Week Course"... "designed for *disabled* and *able-bodied* persons ...." (underlining by writer.) I certainly support the concept of bringing disabled and able-bodied citizens together but there are many ways of doing this in existing community YWCAs and YMCAs, private health clubs if people so desire, school and other public facilities all over the country. And, certainly the concept of emphasizing *ability* instead of *disability* in all persons is paramount.

In conclusion

I am sure that Congressman Erdahl and the faithful and hard working proponents of Vinland Center believe sincerely in their desire to contribute to the needs and aspirations of persons with disabilities. However, it is my earnest hope that serious consideration will be given to the questions raised here. Perhaps passage of Mr Erdahl's bill, with the deletion of the Vinland Center proposed appropriation, would be a solution to the questions raised.

Sincerely,
Dorothy M. Peters, Ed. D.
Self-employed consultant
(at present retained by Courage Center)
Apt. 703, 7201 York Ave. S,
Edina, MN. 55435

(Also person with a disability
who is confined to a
wheelchair)

The Honorable Austin J. Murphy

Mr. Erdahl. Thank you very much, Dr. Peters, for your testimony. I have several questions, but before I do that, I would like to thank you for expressing support for at least other parts of the bill other than the Vinland Center, because I think they are very important.

I might say, as far as the Vinland Center being tacked on to those programs, it was the other way around. I got the support of Mr. LeBoutillier and others with respect to these programs.

I want to thank all of you for fine, perceptive testimony, and I really feel the sincerity with which you come to us and express these concerns. You mentioned that it had been politicized—I don't know if you mean that because we got support from Walter Mondale. John Milton was instrumental in getting $10,000, and Governor Al Quie supported it. We have support from the bipartisan Members of the Congress.

If that makes it political, I hope that is not political in a negative way.

Dr. Peters. The Minnesota matching fund for the $200,000 from our good friend in Norway, my understanding would have been that that would have been from the private sector, and I am a taxpayer, and so that $200,000 is going to be part of my tax dollar, too, friend, and although I am very happy to be able to pay taxes, believe me, I want nothing for nothing, and I don't think any of these people here do.

But I think that this one instance—now, I am not familiar with Vice President Mondale and some of the other very fine people that you have contact with.

However, if those funds had been given privately, I would have been much happier.

Mr. Erdahl. I appreciate that observation, but just a point of reference, maybe, as we think of priorities we pick. I must say I have not agreed with all of the priorities of the present or the past administration, but let us put it in perspective. I think we should talk specifically about Vinland during the few minutes we have left, because other parts of the testimony will come later on TVI and the other programs.

Over a period of 5 years, as I recall from my understanding of the bill, $5.3 million is authorized, part of it for construction, part of it for programs, which is to be matched by private donations, and is to be phased out over a period of time.

This is about a portion of the tail assembly of one B-1 bomber. As far as our foreign aid is concerned, Israel has been much in the news, and I think we should support our ally in the Middle East, yet this is a part of a day's expenditure that we spend on Israel.

We spend $7 million a day on aid to Israel. I think we should put the thing in perspective. My point is not to challenge the wonderful work that is being done at Camp Courage. I guess a fundamental question I would have when you talk about duplicative services, are all the handicapped people in need of services that Camp Courage might be able to provide or the Vinland Center, are they being served?

To put it bluntly, I think there are more than enough handicapped people to go around. Anybody want to comment on that?

Dr. **Peters**. I would be delighted to. No. 1, you speak of Camp Courage. That is one part of the program. Courage Center, as Joyce defined, is the central headquarters for Golden Valley. It administers a total——

Mr. **Erdahl**. I meant the total program.

Dr. **Peters**. However, there are many people who do not realize that Camp Courage is one part of the program, Courage North is another part of the camp program. We have probably the outstanding recreational and sports and physical education programs in the world, and I don't think anybody could again say that.

Bob Simon has coached wheelchair team after wheelchair team and brought all kinds of glory to Minnesota as well as to the United States. Just to refresh the memory of the people out here, the authorization of appropriations from the bill, Mr. Erdahl, authorizes to be appropriated $2,650,000 for fiscal 1984, $2 million to be authorized for the construction of facilities, $1,650,000 for fiscal year 1985, of which $1 million is authorized for the construction of facilities; $400,000 for fiscal year 1986; $300,000 for 1987 and $300,000 for fiscal 1989, which I believe is to conclude at the end of 1989 on the supposition that the center will be self-supporting at that time, correct?

Mr. **Erdahl**. Yes, that is my understanding as well.

Ms. **Vincent**. All disabled persons are not being served by Courage Center, in this area, that is. That is all the more reason not to try to build—waste precious Federal dollars on an unneeded physical plant which is going to take money from the community, the same funding sources in terms of foundations, individuals and companies, for matching funds to build the plant, and then also for operation.

We are finding that income has been cut back. We have had to cut back programs in some areas of recreation, some areas of technical training in the computer field and so forth, simply because of the difficulty in maintaining the full budget that we would like because of cutbacks in the economy.

Now, to impose on that area another physical plant that is going to have to have matching funds sought from the community at large and the operation as well is ridiculous.

Mr. **Erdahl**. Let me ask a question or just make a statement, perhaps, and I think it is a true statement. If money is not provided through this bill or by the Congress for Vinland Center, that is not going to make more money available for places like the Courage Center or other programs for the handicapped.

I think one of the things that several people brought up was money from the community. The Vinland Center concept happens to be located in Minnesota, but it is a national center, a center looking at the exportability of techniques and training, and that is the reason that temporarily handicapped and able-bodied people would also be trained as helpers and guides and people working in this area.

I sense that the bottom line frankly is the competition for funds. You are afraid if this comes in the community funds won't be available. As Vinland is a national center, the funding will be nationwide as well.

My question is, Would you be here in opposition to Vinland Center if it were located in Denver, Colo., or Portland, Maine, or some place else in the country?

Dr. **Peters**. Probably. I don't know those places like I know this place. My comment as far as the Nation is concerned——

Mr. **Erdahl**. Maybe you had a question or comment.

Dr. **Peters**. I wanted to comment on what you just said about being a national center. I would like to, if we had the time, to just give you a rundown of the people not only from this country, the United States, but from every country in the world who have visited Courage Center just in the 16 months that I have been there.

Mr. **Erdahl**. I think it is a fantastic place. I am all in favor of Courage Center.

Dr. **Peters**. We are glad for that. What I am saying is that in a sense, Courage Center and Sister Kenny, as far as that is concerned, have become national centers. They have the potential for becoming even international centers. In fact, we have had international people here for consultations for 2 and 3 days at a time.

I met a member from the Parliament of Israel, a gentleman from Osaka, Japan. I could go down the list—Brazil, Canada, almost every country in the world we have helped in the essence, although we do not have a standing, inplace institute at the moment, which we hope to have in another year, it will be a national source, and we will be working in conjunction with Sister Kenny and other facilities.

Mr. **Erdahl**. I am glad you brought that up because at the risk of being self-righteous, Minnesota does have a reputation for treatment centers, the Mayo Clinic, Sister Kenny, and all the rest—maybe that is one of the reasons in addition to the Scandinavian heritage why the people sought to locate the Vinland Center here, which I would hope would be a cooperative, complementary activity and not in any way at all a competitor to the concepts and to the activity of Camp Courage.

Mr. Schultz.

Mr. **Schultz**. The question that I have in my mind is, as I stated earlier, with the present program under medical assistance which would pay for many of these services, since most of the disabled cannot pay for the services themselves, generally speaking they will not pay for services outside of the State that the person resides in.

The only reason that some people coming into Minnesota receive services for medical assistance in Minnesota is they move to Minnesota and become a citizen of Minnesota. That is the only reason.

I question the medical assistance program being able to cover these services at Vinland Center, even though it will be a national center.

Mr. **Erdahl**. That is a good question. I can't give the answer, but I see my staff has taken a note. We will find out. Thank you for bringing that up. It is a very legitimate concern, because obviously as you say, most people, able-bodied or handicapped, could not probably pay for services if there weren't some type of assistance from an agency, whether at the Federal or State level.

Ms. **Vincent**. You asked the question would we oppose it if it were built elsewhere. I would still question the methodology, but the physical plant, if it were needed in some State without the abundance of physical resources that we happen to have here, I think that my opposition would be somewhat different.

I think trying to fund, let's say, a facility where there are basically the facilities existing 25 miles away at Camp Courage or the same basic facilities we have 25 miles away in the Twin Cities area, much the same facilities, and a lot of the programs proposed to be operated can be operated in communities all over the country, in swimming pools, playing fields, and schools that already exist, and that is the intent I think, to include the disabled in the programs that are already existing wherever possible.

I think the whole concept is at question here as well.

Mr. **Erdahl**. Again, not to be argumentative, the people from Vinland Center will get this in the record, I am sure, my understanding of the concept is to try to have the healthsports concepts, the wellness, stressing abilities rather than disabilities, enabling people to live more independently. This is the whole concept, to export this idea, people trained to help people throughout the country.

So I don't see that as incompatible at all.

Ms. **Vincent**. The point is you don't need this multimillion-dollar facility to do it. The facilities already exist throughout the country. The expertise already exists. It is a matter of just providing the funding for programs. I think there is an important distinction to be made between this Taj Mahal physical plant and program.

Mr. **Erdahl**. Again, the Taj Mahal, that is your description. Others might not describe it that way.

Ms. **Vincent**. The plans are quite grandiose. We don't need to spend that kind of money to build a physical plant in an area that already has more than enough of that kind of facility. Courage Center has offered the use of Camp Courage and Courage North to the Vinland people.

We have tried to work out arrangements whereby those programs would be carried on, but that was not satisfactory. The programs at the camps are operated 4 to 8 months of the year, they would be available for other kinds of programing. Vinland needs basically an office to operate out of, not a physical plant.

The pools, gymnasiums, and whatever exist in YMCA's, schools throughout the country is a matter of sharing the expertise to get the programs going.

If we are going to spend any kind of Federal dollars, you need transportation in those communities to get the people out of their homes. It makes no sense to bring somebody from California, Florida, or Arkansas to Vinland Center and send them back to their community to get a program going if they don't have transportation to get people to the pools or gymnasiums.

There are a lot of services in terms of independent living that are far more needed. In an age when we are experiencing cutbacks of Federal funding we have to look very carefully at how that money is spent and not spend it for unnecessary things.

The physical plant at Vinland is unneeded.

Mr. **Erdahl**. Thank you very much for sharing your opinions with us. My staff reminds me that our time is up, and we have another panel coming. I would mention to you and others in the audience, and I think I can take this latitude with the chairman—the record will be kept open for a period of time for you or others who might wish to submit further written testimony which will be incorporated into the record for use of my colleagues and the staff.

I would like to extend the invitation to feel free to submit testimony that you might have specifically on this or other parts of the bill that we will be discussing throughout the day.

I certainly want to thank members of the panel for coming forth with not only your criticism—sometimes we need to hear that—but also with your suggestions and I hope you will feel free to keep in touch as we go along with this and other programs which are hopefully of benefit to handicapped people in our society.

[Recess.]

Mr. **Erdahl**. Maybe we could call the hearing back to order again, please.

Senator Rudy Boschwitz of Minnesota—welcome—he will be sitting in on the panel. I am not sure how long he can be with us today. Rudy is the author of this particular measure on the Senate side.

I am very glad that he was able to make some adjustments in his schedule to be with us today. Maybe before I introduce the next panel, would you like to make some initial comments? Senator Rudy Boschwitz.

Senator **Boschwitz**. Should I make it verbally or should I sign?

Mr. **Erdahl**. We will put you to the test.

Senator **Boschwitz**. It will be slow, so you will have to be patient with me. When I listen to the news I am often discouraged but when I come here, I am always happy and uplifted because of the wonderful sense that life is good, that we are going to deal with life as we must, and that I sometimes don't find in the so-called outside world.

I have been a supporter of President Reagan in many affairs, but when it comes to education, and particularly education for people who have handicaps of one type or another, I have departed from his cost-conscious approach, because I think that there are no finer programs that the Government undertakes than the training that goes on in this school and schools like it throughout the country.

So I am very pleased to be here at the hearing. I think the bill that I introduced in the Senate has quite a good change of passage, even though it is late in the legislative year.

I have received some cooperation from Senator Weicker, who is the chairman of the Handicapped Subcommittee of the Labor and Human Resources Committee that deals with this.

He, in fact, has received a little cooperation from me on his campaign. So that I have very much in mind that in helping him that he could be of help to this institution and to institutions like this all over the country.

Mr. **Erdahl**. Thank you very much. Let's give Rudy a hand.

I have been aware, because Rudy and I have known each other since we got involved in political activity in Minnesota for a dozen years, and I know him as a super plywood salesman, and as one who is not afraid to stand up to Presidents and others if he has a difference of opinion.

But I am completely flabbergasted that he has taken the effort to learn a communications skill on which many of you depend.

I think that speaks more eloquently than anything that I could say or he could say for the concern that Rudy Boschwitz has for you people.

Senator **Boschwitz**. I learned it when I was a busboy and I worked with some deaf people and I wanted to communicate with them. That was 30 years ago, so I am a little out of practice.

Mr. **Erdahl**. What Rudy learns when he is 5 years old he doesn't forget.

Senator **Boschwitz**. It is like riding a bicycle.

Mr. **Erdahl**. This has been a delightful part of the hearing today. Let's proceed.

We have some very well-qualified experts to share some things with us today. Again, as I mentioned earlier, you are welcome to submit your testimony in a written form. It will be included in its entirety in our record, and you can perhaps, for the sake of brevity and to meet with our schedule summarize if you feel comfortable doing that.

The first panel dealing with the captioned films program is Dr. William Johnson, superintendent of the Illinois School for the Deaf, and Dr. Robert Harris, the president of the Deafness Education and Advocacy Foundation.

Dr. Johnson, since you are first on the list, we will let you proceed at this time.

Dr. **Johnson**. Mr. Congressman, if it is permissible with you, we would like to reverse the order of presentation to you and start with him.

Mr. **Erdahl**. Please go right ahead.

STATEMENT OF ROBERT HARRIS, PRESIDENT, DEAFNESS EDUCATION AND ADVOCACY FOUNDATION

Dr. **Harris**. Good morning, Mr. Chairman.

Before I go ahead, I would like to check to see if you can hear my interpreter. Good morning, Mr. Erdahl.

Senator **Boschwitz**. Does Mr. Harris have prepared testimony, by chance?

Dr. **Harris**. I have a copy of the written testimony for your record, yes. I would like to start over.

Good morning, Mr. Erdahl, and good morning, Senator Boschwitz and other members of the Subcommittee on Select Education and ladies and gentlemen.

I would like to start with a few words of happiness. The reason is because I know both of you, Mr. Erdahl and Senator Boschwitz. I remember when I was applying for a Busch Leadership Fellowship. You were one of the speakers who spoke with us and I enjoyed your speaking.

Also, I am happy to see Rudy Boschwitz here. Three years ago, when I met him as an intern, he did that. I was really impressed with his keeping promises.

On behalf to the National Association for the Deaf, I would like to thank all of you very much for inviting me to address the related services for deaf and other individuals. I am sure that you would like to know a little bit about the Foundation for the Deaf. It is the largest and the oldest consumer organization of handicapped people in America, with more than 17,000 members and 48 affiliated State organizations.

Also, this organization serves as an advocate for more than 13.5 million people who cannot hear. My comments for this testimony will be limited to my perspective as a consumer. I am deaf myself. I have served on many organizations for the deaf and I have a good understanding of what most deaf persons need or hope to get from you.

I think that it would be helpful to start with a brief background of how the previous legislative acts which are similar to your proposal, H.R. 6820, have helped hearing-impaired people.

I would like to say it has helped us a whole lot. For the first time, deaf and hearing-impaired people have felt they were part of America.

Before, we didn't feel we were part of America. We felt we were separated. We had no idea of what American tradition is. We had no sense of patriotism. We didn't feel as though we had support of America.

Without the support of captioned films through many years, we didn't appreciate the life in America. Other examples of how the films have helped us are as follows:

By watching captioned films we feel more socially and culturally sophisticated. The captioned films have helped us to appreciate the historical value of American tradition.

Third, captioned films have helped us to appreciate the tradition of families as one of the most stable institutions among several other alternative styles of living.

As a result, our sense of responsibility to our families is enhanced. Captioned films help us to develop and maintain our language skills.

As a result, we are more motivated to read newspapers, magazines, and other printed materials. We are also motivated to use a TTY, which means teletype writer or telecommunications device for the deaf, as a means of written communication correspondence with other people.

Such contacts maintain our ability to use language skills for social purposes. Captioned films help us to make new friends through captioned movie clubs for the deaf. As a result, we develop and maintain positive interactions with other people.

Such positive interactions help us prepare for the world of work. Also, captioned films make it possible for deaf parents and hearing-impaired adults to lead a richer and more meaningful family life with their children who have normal hearing. Captioned movies make it possible for parents and children to watch movies together.

As a result, many hearing children can join their parents who are deaf. Also, captioned films help us to recruit new people to join social, civic, and cultural organizations for the deaf by saying if you want to watch the films, join us.

The idea is to get more people involved in the community, which contributes to the richer heritage of deaf culture. Such a richer heritage leads to positive self-esteem about being deaf.

When we look at how the films helped us, there is no question that we intend to support H.R. 6820 and hope to get the same benefits that we had so many years before, and we want to applaud your efforts to draft the bill.

However, we would like to emphasize that we have received a lot of positive feelings through new caption technologies. For example, line 21, closed caption technology, the ABC Captioned News from Caption Center in Boston and the computer-assisted telecommunications via TTY and TTD—those are all new caption technologies as a result of what was part of Public Law 94-142.

We have noticed that in your proposal, H.R. 6820, there doesn't seem to be much emphasis on the need to encourage further development of new captioned technology, so we are very much appreciative of your concern to perhaps add a stronger statement in the proposed legislation that would encourage the development of newer caption technology so that deaf people can have access to those captioned TV programs as well as captioned films.

But I would like to emphasize that we are very much in support of captioned films and want to continue to receive the benefits of captioned films.

One more thing I would like to say, and the title of this part is called captioned films and related services for the deaf and handicapped individuals, H.R. 6820. I am wondering if you think it would be a good idea to delete the word "films" and instead put in a new word that would be "media."

In other words, it should be captioned media and related services for deaf and handicapped individuals, so that people would understand that we would like to have also other media like TV captioning, computer technology and so on.

At the same time, I would like to emphasize that we don't want to lose what we have. We appreciate the captioned films. At the same time, I would like to add that if you could find some way to do that, we would appreciate that.

In closing, I would like to thank you so much for your attention to concerns that I have expressed and I trust that you will also give some thought and consideration to my suggestions and recommendations.

Feel free to ask me or the National Association for the Deaf if information is needed. One more thing, I would like to thank Ms. Alina Schroeder for "voicing" my oral testimony in sign language. Thank you so very much.

[The prepared statement of Robert Harris follows:]

PREPARED STATEMENT OF ROBERT I. HARRIS, PH. D., PRESIDENT, DEAFNESS EDUCATION AND ADVOCACY FOUNDATION, ST. PAUL, MINN., ON BEHALF OF THE NATIONAL ASSOCIATION OF THE DEAF, SILVER SPRING, MD.

Good morning, Mr. Chairman. I want to thank you for arranging to have an interpreter for this very special occasion—a Congressional Hearing. Such interpreting services make it possible for me to present my oral testimony in sign language which is translated into spoken language for your convenience. I appreciate your sensitivity to the communication needs of a deaf person like me.

Before I proceed with my oral testimony, I would like to introduce myself briefly. I am Dr. Robert Harris, President of Deafness Education and Advocacy Foundation—a grassroots organization comprised of three significant groups of people who are committed to the full development of deaf individuals as self-sufficient and productive citizens: a) deaf people, b) parents of deaf children, and c) professionals working with this special population. I am trained as a clinical psychologist working with deaf and hearing-impaired people of all ages. I have served or am currently as a chairperson, a board member, or an officer of many local, state, and national organizations of the deaf or the handicapped. To name a few—Vinland National Center, Minnesota State Council for the Handicapped, National Advisory Committee on the Handicapped, and Advisory Council to the Minnesota School for the Deaf. For the purpose of this testimony, I am representing the National Association of the Deaf (NAD). NAD is the oldest and largest consumer organization of handicapped people in the United States, with more than 17,000 members and 48 affiliated State Associations. It serves as an advocate for the more than 13½ million deaf and hearing-impaired people living in America.

On the behalf of the NAD, I want to express my gratitude to you for the invitation to address to the Title IV—Captioned Films and Related Services for Deaf and Other Handicapped Individuals, House Resolution 6820—The Handicapped Individuals Services and Training Act. I understand that you would like me to focus my testimony on the merits and likely impact of this proposed legislation which would provide for an indefinite authorization for the Captioned Film Services Program on the welfare of deaf and hearing-impaired people. My comments to be presented below are primarily focused on matters of most interest to us as deaf and hearing-impaired consumers, in the belief that other advocates will address critical issues outside on this framework. I would like to make three general comments. They are as follows:

I. THE IMPACT OF PREVIOUS LEGISLATIVE ACTS ON THE WELFARE OF DEAF AND HEARING-IMPAIRED PEOPLE

We want to acknowledge our utmost gratitude to the Congressmen for their long-term federal sponsorship of captioned films and other related media services to this special population. The sponsorship included six previous legislative acts (Public Law 85-905, Public Law 87-715, Public Law 89-258, Public Law 90-247, Public Law 91-61, and Public Law 94-142). These legislative acts have resulted in many rich dividends for deaf and hearing-impaired adults. Several examples are presented below to illustrate the benefits of these legislative acts.

A. They enriched our ability to derive enjoyment from watching captioned films. As a result, we have become more socially and culturally sophisticated.

B. They helped us appreciate the historical values of American tradition by viewing films made in America. As a result, our sense of patriotism and loyalty to our country is enriched.

C. They helped us develop an appreciation for the tradition of a family as the most stable institution among several alternative styles of living. As a result, our sense of responsibility to our families is enhanced.

D. They helped us develop and maintain our language skills. As a result, we are motivated to read newspapers, magazines, and other printed materials which help us keep up with current happenings in America. Also, we are motivated to use more often a teletypewriter (TTY) or a telecommunication device for the deaf (TDD) as a means of written communication correspondence with other people. Such contacts maintain our ability to use language skills for social purposes.

E. They helped us make new circles of friends through captioned movie clubs for the deaf. As a result, we develop and maintain positive interactions with other people. Such interactions accelerate our interpersonal skills which are a prerequisite for competitive employment in the hearing world of work.

F. They made it possible for deaf and hearing-impaired adults to lead a richer and more meaningful family life with their children who have normal hearing. Availability of captioned movies make it possible for both parents and children to enjoy watching the movies together. As a result, many children grow up as healthy, productive, and self-sufficient adults.

G. They provided us an incentive to recruit new people with hearing impairments to join social, cultural, and/or civic organizations of the deaf by inviting them to watch captioned movies. As a result, more deaf/hearing-impaired individuals are involved in the community activities which contribute to the rich heritage of deaf culture. Such a rich heritage leads to positive self-esteem about being deaf.

II. OUR REACTIONS TO THE DESCRIBED INTENTS OF TITLE IV, H.R. 6820

We have reviewed carefully the contents of the Title IV, H.R. 6820 and compared the merits of this proposed legislation with previous legislative acts as specifically mentioned above. We generally are pleased with the efforts expended by the Subcommittee on Select Education, its chairman Mr. Murphy, and Mr. Erdahl, to draft this part of H.R. 6820 so that the benefits of the captioned films, which deaf/hearing-impaired people have so much enjoyed for many years, would be maintained indefinitely. Our pleasure with the subcommittee's efforts is based on three findings:

A. We gratefully note the Congress's acknowledgement as mentioned in the H.R. 6820 that the Federal Government has a responsibility to promote the general well-being of deaf and other handicapped individuals by adapting and distributing existing media and materials in a way which assures broader accessibility for such individuals. Such an acknowledgement is in line with the other legislative act passed by the Congress, called the Rehabilitation Act of 1973 as Amended. The Rehabilitation Act guarantees handicapped individuals the Bill of Rights or, in other words, full accessibility to the mainstream of American society.

B. We are pleased to note the Congress' acknowledgement as mentioned in the H.R. 6820 that the adaptation and distribution of media for handicapped individuals will provide enriching educational and cultural experiences for such individuals, and should contribute to their understanding of any participation in their environments. Such an acknowledgement reflects the Congress' belief that deaf and hearing-impaired people have the right to access to educational and cultural information readily available to hearing persons, but inaccessible to deaf/hearing-impaired people in the absence of federal sponsorship of captioned films and other related media services.

C. We gladly note the Subcommittee's efforts to permit the distribution of captioned films and other related media services not only to those people who cannot hear, but also to teachers, parents, employers, and other persons directly involved in the advancement of handicapped individuals. Such efforts reflect the Subcommittee's belief that every group mentioned above has an equally important share of responsibility in promoting full integration of deaf/hearing-impaired individuals to the mainstream of the American society.

In view of the foregoing comments, we feel that the passage of this resolution would guarantee the provision of a continuing service, resulting in greater, more convenient access to educational and cultural information readily accessible by non-deaf individuals. We strongly believe that without federal intervention there is no way for us to have access to captioning services. We therefore endorse and support the Subcommittee's efforts to achieve the described intents of H.R. 6820. However, we are deeply concerned about a lack of intent as expressed in the resolution to encourage further development of new captioning technologies. This matter is discussed further in the next paragraph.

III. RECOMMENDATIONS: INSERTION OF A STATEMENT TO ENCOURAGE FURTHER DEVELOPMENT OF NEW CAPTIONING TECHNOLOGIES

We want to acknowledge that like the inestimable benefits derived from watching captioned films, we are equally grateful for the results from previous legislative acts, particularly Part F of Public Law 94-142, which led to new technology developments, such as:

A. Line 21 closed captioned technology.

B. ABC Captioned News from Caption Center WGBH-TV in Boston.

C. Computer-assisted telecommunications via TTY-TDD.

Closed captioned technology, for example, make it possible for us to have access to a significant amount of captioned materials available through broadcast television. What radio and television are to hearing people, closed captioned television programs are to deaf people. However, we note that what is available for us through closed captioned television materials is only a very small proportion of programming to which the hearing public has access. In view of NBC's most recent decision not to caption new television programs at its own expenses and CBS's long-term refusal to caption such programs, it becomes increasingly crucial that the Congress, or hopefully your Subcommittee, find creative and innovative ways to provide to commercial television networks, as well as cable television companies, monetary incentive to make, continue, and/or expand the production of closed captioned programs not only for regular television broadcasting but also for cable television, computer-assisted telecommunications, and other related new captioning technologies. Therefore, we would like to suggest to the Subcommittee on Select Education to include a strong intent or statement in the resolution to request sufficient federal appropriations for which non-profit and profit-making institutions could apply to develop newer and more cost-effective technologies to produce more closed captioned programs for regular and cable television distribution and computer-assisted telecommunications. Also, additional appropriations should be requested to encourage new technology developments of open captioned television programs.

What we are trying to say is that we the deaf and hearing-impaired people have the right to access to information that is readily available to hearing people. Many hearing people depend on television as their primary source of news and information. Television is used to broadcast the news of the day, presidential addresses, political debates, weather advisories, educational programming, public information, and emergency announcements of impending civil emergencies or natural disasters. Even though television transmission results in a visual image, television broadcasting presumes viewers have hearing that is good enough to enable them to obtain information primarily by auditory means. Without the provision of supplemental visual information, television viewing is out of the question for many deaf and hearing-impaired people.

In view of the foregoing comments, may we suggest that the Subcommittee on Select Education consider deleting the word "Films" on line 12, page 16 of the H.R. 6820 and insert a new word, "Media" to emphasize the Congress' intent to support further developments of new captioning technologies to promote broader accessibility for deaf and hearing-impaired people.

In closing, Mr. Chairman, we want to thank you so much for the attention of the Subcommittee on Select Education to the concerns we have expressed and trust that you will also give thoughtful consideration to the suggestions and recommendations which we have made. At your request, we would be happy to supply additional information supportive of recommendations which you may find of particular interest. And, one more thing, we also want to thank Ms. Alina Schroeder for "voicing" my oral testimony in sign language.

Mr. ERDAHL. Thank you so much, Dr. Harris. I think we have questions and comments.

Why don't we go to the second member of the panel, again for the record and for our court reporter, Dr. William Johnson, superintendent of the Illinois School for the Deaf. Welcome, Dr. Johnson to Minnesota.

STATEMENT OF WILLIAM JOHNSON, SUPERINTENDENT, ILLINOIS SCHOOL FOR THE DEAF

Dr. JOHNSON. Thank you very much, Congressman Erdahl. I am glad to see the Senator here. I will be addressing my comments to the captioned films section of this proposed bill only.

As you noted, I am the superintendent of the Illinois School for the Deaf. There are two or three or four other reasons why I am here. I am a deaf individual who has a son going to the Illinois School for the Deaf. I am an educator of the deaf.

I am an administrator of a captioned film depository at our school. Also, I am representing two national organizations here, the Convention of American Instructors of the Deaf, CAID, and the Conference of Educational Administrators Serving the Deaf, CEASD.

Our position is that we endorse and support the efforts to achieve the intent of this bill, H.R. 6820. I think at this point maybe I will drop my signing because I think there are enough people here that are going to be blocking everyone's view, anyway.

As noted, we do endorse what you are doing. The captioned films program is a service program, not a research or a demonstration program. For over 20 years, its effectiveness has been demonstrated and the statistics are significant. You will note that I am not reading from the written testimony that I have prepared.

Within the written testimony, the statistics are there. We in the education field of the deaf believe sincerely that captioned films have made a difference. We appreciate what you are proposing in this bill in establishing separate legislative authority that will, one, protect the financial base of the program; two, better emphasize the interest of the adult disabled population; and, three, create a situation in which this program would receive greater visibility and, subsequently, we believe more support.

When people understand what we are doing, they support the effort, and I believe this is true with you people. In education, and particularly at the Illinois School for the Deaf, we see captioned films making a significant impact on the reading achievement levels of our deaf students.

Language development is the key to our success as deaf individuals. As noted in the written presentation, the adult population likewise has made good use of the captioned films project.

Within the written presentation, specifically in the appendix in pages 1 and 2, we have proposed several suggestions that we believe would strengthen this bill. The deaf need more access to technology and the visual medium.

Deafness is the most difficult disabling condition to work with educationally. The potentials are unlimited. We hope that in the presentation of your bill, you will continue to focus it in on the deaf population and that you will also look at the possibilities of expanding technology in this area of captioned films, the visual medium which is so important to those of us who do not hear.

I will conclude here, indicating to you we are extremely appreciative of the efforts of you, Congressman Erdahl, who are holding this subcommittee meeting, Senator Boschwitz for coming and being more aware, and we want to thank you for your insight and concern for maintaining the benefits of the captioned films project.

I will conclude with that, and thank you for inviting us.

[Material submitted by William Johnson follows:]

Prepared Statement of Dr. William Johnson, Superintendent, Illinois School for the Deaf, Jacksonville, Ill., on Behalf of the Convention of American Instructors of the Deaf, and the Conference of Educational Administrators Serving the Deaf

Congressman Murphy, Congressman Erdahl and members of the Subcommittee on Select Education: I am Dr. William P. Johnson, Superintendent of the Illinois School for the Deaf. I am here today to present testimony on bill H.R. 6820, the Handicapped Individuals Services and Training Act. My comments will be with particular reference to Title IV—Captioned Films and Related Services for Deaf and Other Handicapped Individuals. My interest in this bill, and in the captioned films for the deaf project itself, arises from three interfacing factors. First, as a severely hearing impaired individual who has a hearing impaired son attending the Illinois School for the Deaf, I am vitally interested in this project. Second, as an educator of the deaf, I note that the educational achievement of the deaf is greatly enhanced by captioned films. Third, as the chief administrator of one of the largest, most active educational captioned film depositories in the United States, it is readily apparent that these films are used extensively and effectively.

As you are aware, the captioned films for the deaf program has proven itself for over twenty (20) years. In 1958, with the enactment of Public Law 85-905, the deaf were afforded a new avenue in meeting their instructional and general interest needs. While over 1,100 educational films have been selected for captioning, this number represents a very small percentage—specifically, less than three percent—of the educational films available to the public at large. It is obvious that the educators of the deaf have very limited practical availability of educational films, and rely extensively on those that are captioned. The utilization and effectiveness of such films is exemplary. To this end, this project is extremely important to us as educators and consumers.

The Illinois School for the Deaf has made visual media utilization an integral part of our overall educational curriculum. Educational captioned films are one very important component. Appended to this presentation is a written comment by one of our students on the value of educational captioned films in the classroom. It is also noted that our school records indicate that students in our system for more than four years accomplish reading achievement levels above the expected norms. We attribute this in part to the extensive utilization of captioned visual materials.

Captioned films, captioned television, and computer support applications have been important technological assistance advancements in the education of the deaf. We look forward to the day when the further utilization of films, television, computers and related technologies can be adapted for the educational needs of the deaf. We suggest that research in technological advancements in this area be an integral part of this bill.

While emphasizing educational captioned films, it is noted that the educational films are not the only component of the captioned films project. General interest films have also been captioned, and extensively utilized across the country. The one thousand films available constitute a very small portion of the existing general interest films. In the Jacksonville (Illinois) deaf community alone, we have captioned, general interest films shown at least twice a week. The target population includes some five hundred deaf individuals. These films have provided a meaningful addition to the lives of the deaf student and adult.

There is little question that captioned films have enhanced the educational process for the deaf. They are important to us in the field of the education of the deaf and to those of us who cannot clearly comprehend the auditory aspect of films. We are extremely interested in expanding the captioning concept to other visual mediums for the purpose of the education of the deaf. The deaf have long been considered a "silent minority" with an "invisible disability." Deafness is the most difficult disability with which to work and obtain success in the educational process. We, the deaf, need the full impact of this bill. The existing and proposed resources for the captioned films project do not provide an opportunity for full utilization with the deaf. It is suggested that this bill focus on maximizing services to the deaf before expanding the service to other disabled populations.

Statistics will indicate to you the importance we place on the utilization of these films. On the national level, approximately 250,000 separate films are borrowed annually, accounting for several million separate viewings. Of this number, some 100,000 have been educational captioned films, and they have reached some 1,700,000 deaf/hard-of-hearing students.

During the last three (3) years, the Illinois School for the Deaf circulated over 9,000 educational captioned films through our depository. Over one hundred schools/programs for the hearing impaired within the State of Illinois received the films. In addition, we have provided numerous schools in Indiana, Kentucky, Michigan, Ohio and Wisconsin with these captioned films. During the past three years approximately 100,000 students have seen these films.

When Drs. Boatner and O'Connor organized the first Captioned Films for the Deaf, Incorporated, a library of some thirty (30) captioned films were made available to schools for the deaf across the country. The demand for these films exceeded their availability. Adequate financial resources did not exist to expand this project. There was not a large enough target population for the private sector to pursue this project.

With the enactment of Public Law 85-905 a whole new instructional support strategy was made available to us in the education of the deaf. These films are now an integral part of our instruction process.

We are concerned that the Reconciliation Act of last year removed permanent authorization of the captioned films program. As noted previously, the private sector has not demonstrated, or expressed, an interest in this activity. The profit margin is just too small.

We need a continuation of the captioned films program. We need to have the program concentrate on providing, and developing, services to the various subpopulations of the deaf community. There is little question that technology has made rapid advancements during the past decade. Many of these advancements could, and should, be researched further for their applicability to the deaf populations.

In closing, I want to note that the deaf education community has been extremely appreciative of your past support of the captioned films project. While there are concerns and recommendations to this subcommittee on this proposed legislation, I want to express the appreciation of those of us in deaf education to you, Chairman Murphy, and Congressman Erdahl. Your interest and insight into the continuation of this project, while having a subcommittee hearing to obtain further input from the consumer, reflects well on your sincere interest in this meaningful project.

Thank you.

FILM UTILIZATION: A STUDENT'S VIEWPOINT

By Christy Beckwith

Christy Beckwith, a gifted 14-year-old deaf student, is a freshman in high school at Illinois School for the Deaf. She has attended I.S.D. for eight years and is a day student living at home with her parents, two sisters, and two brothers.

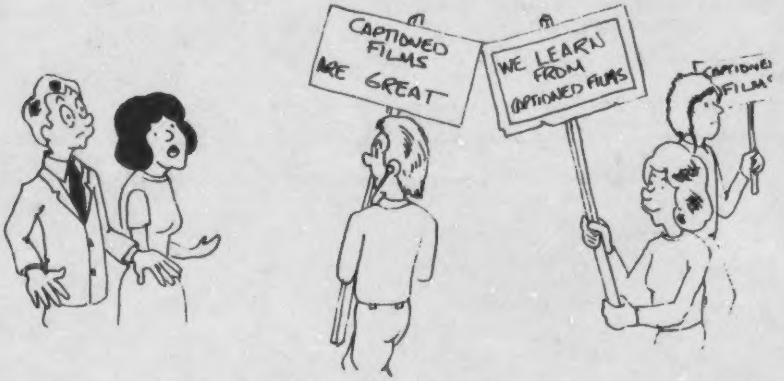
From my viewpoint, that of a deaf student, captioned films are an essential part of deaf education. Without captioned films, much of value would be lost to us, the deaf students.

Personally, I prefer films such as those shown in social studies, the ones showing different cultures, and I think we should have more of these films. Also, the ones shown in social hygiene are good. I think that the Captioned Films Workshop should caption some films showing live-action scenes. I have seen some films on child abuse, emergency childbirth, and births that were not captioned, and the teacher interpreting often had a hard time keeping up with the spoken sequence. In such cases, we can't see as much of the film, because we have to watch the interpreter part of the time. It would be a lot easier on both the teacher and us if some of these films were captioned.

Different teachers use films in different ways. Some teachers like to tell us a little about the film before starting the machine. I feel that is a good idea, as it lets us know what to expect, and what to learn from the film. It increases our awareness of the film, as does discussion after the film.

One thing that most of us dislike is when, during a captioned film, the teacher stands in front of the room, near the screen, and repeats what the captions can tell us by themselves. Of course, it is sometimes necessary for some parts that are difficult to understand, but I think it would be better if the teacher would wait until after the film, when we could discuss it, and ask questions about things we don't understand about the film. In short, it is an excellent idea to discuss a film.

Sometimes, I think it is a good idea to show the same film twice, such as for preparation for a test, quiz, or exam. Also, if the teacher shows a film with a difficult point to grasp, it might be a good thought to show it again. Other than these two cases, I find it dull seeing the same film twice. I feel that visual aids are necessary, and that without captioned films, teachers could not teach us as much as they can with captioned films.



"THEY SAY THEY AREN'T COMING BACK TO SCHOOL UNTIL WE PROMISE TO SHOW A CAPTIONED FILM."

BACKGROUND INFORMATION ON CAPTIONED FILMS FOR THE DEAF AND TITLE IV OF H. R. 6820

A. Need for the Provisions of Title IV of H. R. 6820

- The captioned films program originally had a permanent authorization. This permanent authorization was removed last year in the Reconciliation Act. H. R. 6820 would restore this through a provision in Sec. 404.

- The captioned films program was originally intended for the adult population and subsequently the student population of deaf persons. It is currently placed with the Education of the Handicapped Act and administered through agencies which have a primary focus on the school-age population. A separate authority may better emphasize and protect the interests of the adult handicapped population.

- There have been various indications of interest in establishing an administrative framework within which various line items within P.L. 94-142 could be reallocated at the discretion of the secretary to other areas covered by the law. Establishing a separate lesiglative authority would tend to protect the financial base for this program.

- The captioned films program has always been, at its basis, a service program, not a research or demonstration program, and should not be considered discretionary. A separate authorization would tend to emphasize this value.

- A separate authority may create a situation in which the program would receive greater visibility in the appropriation process, and as a result might receive more adequate funding. Funding for this program has not been maintained at a sufficient level.

B. The Position of the CEASD and CAID

We endorse and support efforts to achieve the described intents of H. R. 6820. We greatly appreciate the interest of the Subcommittee on Select Education, its chairman, Congressman Murphy, and Congressman Erdahl, and their insight and concern for maintaining the benefits of the captioned films program.

We understand the general intent of H. R. 6820 to be the establishment of an improved basis for continued operation of the captioned film and related media services program. We want to try to assure that in achieving this goal the deaf beneficiaries of the program are not placed in a weekened position in the competition for services.

We appreciate the opportunity to express our concerns and interests and wish to make several suggestions which we believe would strengthen the bill.

- Captioned Films per se has been a service designed to meet a specific communication deficit of the hearing impaired. The basis on which the rights to distribute films is negotiated includes the premise that deaf viewers, borrowing the films at no charge, will not reduce the audience for films in commercial theaters. In order that there be no question that captioned films should be loaned to other audiences, we suggest the addition of the qualifier "for the deaf" after the term "captioned films" in Sec. 402(a) (line 11) and Sec. 402(b) (line 25).

- It would be detrimental to the interests of improving efficiency of operation and remove a means of assisting deaf persons in use of new technology if the language of Title IV were interpreted so narrowly as to exclude the exploration of new technology in making educational and cultural information accessible to deaf persons. We suggest that Sec. 401(3) be changed by the insertion of the words "newer technologies" immediately prior to the words "adapted media and materials" (line 3, page 17) and substituting the word "technologies" for the word "media" in Sec. 402(b)(5) (line 7, page 18).

- As pressures mount for cost reductions in various programs, it would be detrimental and unfair, we believe, should the administering agency establish a policy of assessing usage fees for use of the captioned films for the deaf. Deaf persons currently must organize to purchase film projection equipment in order to use the films. Deaf persons pay return postage for films borrowed. We would suggest insertion of the word "free" to modify the term "loan service" in Sec. 402(a) (line 10). This would be consistent with historical and current practice in the film program.

- There is likely to be a need, from time to time, to develop original materials to support the program of captioned films. An example of needed original material might be training materials to assist teachers in making improved use of captioned films in the classroom. If the language of H. R. 6820 were interpreted narrowly by the administering agency, the development of needed materials in support of the program might be precluded, since it would not be likely that other funding programs would view such development as one of their priorities. We suggest the insertion of the word "producing" in Section 401(1) after the word "adapting" in line 19. We further suggest in Sec. 402(b)(5) (line 8, page 18) the inclusion of the word "production" after the word "adaption."

- It is important that teachers, parents, and others concerned with advancing the interests of the handicapped have access to the educational media and materials available through the captioned films and media services program. The extension of this service should not include the general interest (theatrical) captioned film material due to reasons related to the distribution agreements with suppliers. We suggest the inclusion of the words "for educational purposes" immediately after the term "materials" in Sec. 401(3) (line 4) which would emphasize the restrictive characteristics of the specific collection of materials.

C. A Summary of Legislative History Behind the Current Captioned Films Legislation (Part F, P.L. 94-142)

1959	P.L. 85-905	Established Captioned Films for the Deaf program to caption and distribute general interest films for deaf persons.

1962	P.L. 89-715	Expanded authority to include acquisition and distribution of educational media for deaf students.
1965	P.L. 89-258	Authorized distribution of media support equipment.
1968	P.L. 90-247	Extended educational media services to all handicapped.
1969	P.L. 91-61	Established a National Center of Educational Media and Materials for the Handicapped.
1975	P.L. 94-142	Changed National Center to Centers on Educational Media for the Handicapped.

It is worthy of note that early program emphasis was on cultural and educational film-related services for the deaf, with subsequent expansion of thrust related to educational (but not general interest) emphasis in regard to services for other handicapped persons.

D. A Comparision of Provisions of Part F of P.L. 94-142 and Title IV of H. R. 6820

Part F of 94-142	Title IV of H. R. 6820
Sec. 651(1) focuses on provision of access to enriching educational and cultural experiences which deaf persons may share together as a purpose of the program.	Sec. 401(1) recognizes the responsibility of the government to promote the welfare of the deaf and other handicapped persons by adapting and distributing material in ways which make them accessible.
Sec. 651(2) identifies promotion of research in the use of media, production and distribution, and media training as purpose of the program.	Sec. 401(2) acknowledges that adaptation and distribution should assist the handicapped to better understand and participate in their environment.
Sec. 652 establishes a loan service for captioned films (for the deaf) and educational media (for all handicapped): Provides for the government to acquire media and the rights to media; for the captioning of films; for equipment acquisition; for research in use of media; for production and distribution of media; and for training in the use of media.	Sec. 402 establishes a loan service for captioned films and educational media to make them available to handicapped persons, parents, and other persons directly involved in advancement of the handicapped and provides for the acquisition of films and/or rights, for the captioning of films, distribution of captioned films, and other activities (omits research in the use of media and training in the use of the media).
Sec. 653 establishes centers on educational media and materials for the handicapped as a means of facilitating the use of new technology in educational programs for the handicapped through designing, developing, and adapting instructional materials.	No comparable section.

E. The Long-Term Pattern of Funding for Captioned Films and Television for the Deaf

In 1968 the captioned films program funded film acquisition for four regional media centers to promote effective use of media and technology in education of the deaf and film distribution with a budget of $6 million.

In 1978, under part F, a variety of programs for the handicapped had been added. The budget for captioned films acquisition, distribution, and captioned television activities was $8.5 million (and regional media centers has been disbanded along with termination of training in media utilization).

In 1982 the budget for captioned films and television is approximately $5.8 million.

The above pattern of reduction contrasts with increasing demand on all aspects of the captioned films distribution system and the increasing interest and demand for closed captioned television programming. Increases in cost efficiency cannot be expected to counterbalance major reductions in financial support in the face of increasing demand.

F. Characterization of the Scope of Captioned Films Activities for the Deaf Funded Under Part F of P.L. 94-142

Funds have been expended in acquisition of general interest and educational captioned films, their captioning and distribution. In addition to film-based media, significant work has been accomplished in the development of the closed captioning technology. More recently funds have been allocated for the actual captioning of films for television distribution. Much of the broadcast captioned material to date has been underwritten by charges to the participating networks. Approximately one-half of Part F funds are currently allocated for services beneficial to the deaf population.

- A collection of 1,000 general interest captioned films has been built for national distribution from a central library to registered groups of deaf persons who provide their own projection function and pay return postage only.

- A collection of 1,100 educational captioned films for classroom use has been developed and is distributed through 58 cooperating depositories which absorb the majority of the cost of circulation. This collection of educational films provides access to deaf students to perhaps 5% of the educational film titles available to hearing students.

- Approximately 7,000 groups of deaf persons are registered for the purpose of borrowing general interest captioned films.

- Approximately 3,000 schools/programs are registered users of educational captioned films. In a recent year, registrations increased by 15%.

- Approximately 250,000 separate films are borrowed annually accounting several million separate viewings. The demand for film loans continues to increase even though there is now closed captioned material available on television for deaf persons who use line 21 decoders.

- Line 21 closed captioned technology has been developed largely due to federal program support and now makes a significant amount of captioned material available through broadcast television--albeit it is a small proportion of programming to which the hearing public has access.

- Efforts have been made toward the development of technology through which deaf users of TTY/TDD devices will have access to computer assistance which can make their use of the phone system more cost effective and helpful in their daily lives without the necessity for individual investment in microcomputer terminals.

- Through computer support applications in film distribution, significant savings have been introduced which have permitted an increase in the rate at which educational captioned film titles are added to the collection.

The exploration of new technology to support the intent of distributing film content to deaf persons, and to assist in their use of technology has permitted the program to operate cost efficiently, and continued exploitation of new technology will be critical to future improvements in program quality and efficiency.

Mr. **Erdahl.** Well, thank you very much. I really appreciate not only the insight that both of you bring from your personal experience, but also the specificity of your personal experience, and of your suggestions.

I think we think of films as motion picture films, but obviously we have TV and also computers and radio games, and the new age of electronics.

Dr. Johnson, I appreciate the specific suggestions that you made for improving on this legislation. I think that is so important, and that is really what this hearing is all about, not necessarily to get words of support, but to get suggestions whereby we can make it better.

Senator Boschwitz, do you have any comments or questions at this point?

Senator **Boschwitz.** I noted that Mr. Harris spoke about the national agency——

Mr. **Erdahl.** We have to call them both Doctor. We made an error in the thing.

Senator **Boschwitz.** Bob Harris.

Mr. **Erdahl.** That is even nicer, OK.

Senator **Boschwitz.** He spoke about the National Association of the Deaf as a consumer organization. Would you expand on that? Would you tell me a little bit about the meaning of the word consumer, and would you also tell me about the activities that you undertake?

Mr. **Harris.** The National Association of the Deaf was established more than 100 years ago because deaf people noticed that they did not get—so that people from all over the country came together to set up an organziation so they could voice their concern that they have a right to participate in things in America, and that was the reason that they have always been strong advocates of deaf people's rights, through the National Organization of the Deaf we have got Congress to pass secondary films for the deaf and many other programs for the deaf.

And now the National Association of the Deaf is very concerned that deaf people are not getting as much as hearing people are getting. For example, on TV, hearing people depend heavily on TV as the largest source of information through the day, Presidential speeches, political debates, and so on.

They have to wait until the next day to read this in the newspaper or next week, they get it in a magazine or something like that.

So the National Association of the Deaf, through representatives appointed by their State associations to mandate that the National Association of the Deaf invest a lot of their time and money and energy and ask Congress for a broader accessibility to TV through innovative captioning—what they are, I do not know, but the National Association of the Deaf is ready to provide more specific information if it is needed.

I hope that answers your question. Is that sufficient?

Senator **Boschwitz.** Yes; that is. I think I am a little deaf myself, so speak as loudly as you can.

Mr. **Erdahl.** I think maybe we are about finished with this panel, because obviously your testimony goes into the record and we have very tight time schedule, so maybe we could have a few more questions.

Senator **Boschwitz**. Let me ask Dr. Harris one more question.

You said that you wanted a stronger statement on captioning technology. What were you referring to and what kind of technology is developing with respect to captions?

Mr. **Harris**. In this proposal, we are talking about funding to continue the provision of captioned films. I don't see any words or statements which says we want to encourage the development of newer captioning technologies for closed-captioned TV programs, for computer-assisted technology programs.

It doesn't say anything like that. We are a little bit afraid that if you left it as it is, perhaps the Government would say well, it doesn't say anything, so they won't give money to developing new things.

So what I would like to do is ad[illegible]atement so that there is money for people to develop new c[illegible] technology and at the same time provide more services to d[illegible]e.

Senator **Boschwitz**. Let me ask the [illegible]stion in a little different way. That is, how can captioning technology be improved, in what areas need it be improved?

Mr. **Harris**. We have captioned films, which are fine, but we need films—we just order the films now. The only problem is that it takes time to receive the films. For the closed-captioned TV programs, we have no control. The TV networks decide what they would like captioned or not. We have to pay a lot of money to actually buy the decoders so we can see the captioned programs, but they don't always show the captioned programs on TV.

My concern is to buy more decoders. If we hear that they might even code the captioned programs on TV, I am concerned. I would like to see Congress do something to encourage the TV networks to continue to produce closed-captioned TV programs.

That is our biggest priority.

Mr. **Erdahl**. I see that Dr. Johnson seems to be interested in responding to your question.

Dr. **Johnson**. I think, Senator, we could improve on the captioned technology if we could get computer-assisted instruction into the arena that would attract deaf people more appropriately.

How can we take the mediums that exist, films, television, the computer, whatever, and bring that into the life of the deaf individual and the deaf education procedure?

Specifically, news, the instantaneous part, the widespread availability, and I don't believe that we have begun to look into the area of how to use computers in a visual way for us, and I think that is something that needs to be addressed.

Senator **Boschwitz**. It would seem to me to be a national concern.

Dr. **Johnson**. I would agree.

Senator **Boschwitz**. Research to see how you could utilize computers, how you could utilize TV more than it is now, or include more captioned programs, is what you mean by improvement of caption technology?

Mr. **Harris**. Right.

Senator **Boschwitz**. Thank you.

Mr. **Erdahl**. Thank you very much for your fine testimony, and again, as I told the other group that was here before, we will keep the record open for a reasonable length of time if you have other things that you wish to add as you hear the other witnesses, feel free to submit that.

Thanks to both of you, Dr. Johnson and Dr. Harris, for being with us this morning.

At this time, I will call up the other panel and we will try to keep moving right along. On this panel is Mr. Ed Opheim, the Minnesota director of vocational rehabilitation; Norman Sellman, who is the parent of vocational technical students; and I want at this time to welcome the other students who are here as observers in the audience today; Dr. Robert Lauritsen, division manager, special needs, St. Paul Vocational Technical Institute; and Jenny Kron, director of the handicapped placement program, the AFL-CIO Human Resources Development Institute, accompanied by Bruce Mitchell, Basic Industries, Inc.

Just as a personal aside, three of us sitting here today happened to be at St. Olaf College at the same time, once upon a time, I could tell some rather interesting stories about their antics there. Not out of kindness, I will refrain from doing that, because I am afraid they will tell more about me.

STATEMENT OF ROBERT LAURITSEN, DIVISION MANAGER, SPECIAL NEEDS, ST. PAUL VOCATIONAL TECHNICAL INSTITUTE

Mr. **Lauritsen**. Mr. Chairman and Senator Boschwitz, we are absolutely delighted that you are here. We are absolutely delighted that you both have seen fit to introduce the legislation in the House, 6820, and we are here to speak about title III of that bill.

I am going to briefly summarize my remarks because we have a very exciting panel and the panel addresses the real needs of the legislation which is serving deaf people, serving families of deaf people and serving industry.

We have prepared some charts for you which are on the board on your left. I would like to briefly run through those charts.

Mr. **Erdahl**. To inform the members of this panel, I am not sure if you were here when I made the statement before, any written testimony will be included in its entirety in the record, so if you summarize, that will not mean that your other testimony will be ignored.

Mr. **Lauritsen**. We have been aware of concern about what is known as rubella or German measles that swept across America in 1964-65. The first chart shows that birth rate. That chart shows that there were 8,000 young persons born of mothers who had German measles or rubella. There were 8,000 more young deaf persons born than the normal birth rate incidence of 7,500 for a comparable time period.

We are very much concerned about what we call the rubella bubble. That bubble is moving through the end of secondary school and those students are starting to come out of secondary schools.

The middle chart indicates the numbers of students graduating from schools in 1982, 1983, 1984, 1985, and 1986, and you can see a great deal of similarity in the birth rate chart and the school leaving chart.

The school leaving chart is flattened out a little bit, which is a strong indication that rubella children have a little more difficulty in coming through the secondary schools. They don't come out in exactly the same order.

Research shows very closely, and I am sure Dr. Johnson from Illinois can substantiate, that 40 percent, approximately, of those children that were born with rubella have handicapping conditions in addition to deafness.

Going over to chart 3, we have taken the graph and turned the graph into numbers for each of those years, and you can see that in 1982 there are over 3,600 graduates from secondary schools for the deaf.

That number will go to 6,900 in 1983. That number will go to 6,700 in 1984, to 5,655 in 1985, and in 1986 to 5,952, for a total of almost 27,000. This is the largest number of deaf high school students to graduate from schools for the deaf in the history of the United States.

Because of the regional education program, which started in the late 1960's, we have more secondary school graduates who are looking to postsecondary education, to St. Paul TVI and our fellow schools, than we have ever had before.

Before establishment of these programs, only 10 percent of deaf high school graduates looked for postsecondary education opportunities. Because we have these regional education programs, we now have almost 90 percent of deaf school graduates looking for postsecondary education. That in itself is a very significant change.

We used to talk about the stereotype jobs that deaf people have, used to have in the old days. There were very few occupations that deaf persons could go into. I am very pleased to report to you that here in this program at St. Paul TVI and through our consortium programs that we have had deaf students trained in 181 different majors.

That is a lot of majors for students to go into, and a dramatic change from 10 to 15 years ago. Of the almost 27,000 that will be graduating, we feel that over 23,000 will be looking for post secondary education.

We base that on a survey that we did earlier this year of upper Midwest schools, and we took that survey result and projected it to the national number of schools in the country. Deaf students are able to succeed here at St. Paul TVI and in our sister programs because of the support service model that we offer.

I asked one of our artists here in the school to describe that pictorially, and I was very pleased when that person decided to use that middle model above our reporter, and that is the sun shining.

I think that is very appropriate that an artist would elect the sunshine to describe the various support services that we do have, those support services being a preparatory program, counseling services, financial aid, interpreting, notetaking, tutoring, auditory training, consortium programs, continuing education, job placement and follow-up, interpreter training programs, extracurricular programs, and public awareness programs.

Since we began our program in 1969 here at TVI, we have been very aware of the need to demonstrate that what we are doing or attempting to do is a worthwhile effort, and we are very much aware particularly today of the need for programs to demonstrate cost-effectiveness.

So we have routinely kept follow-up data on our students, tried to track them in industry, what kinds of success rates they are having, and their incomes, and we have, since 1974, been talking about a profit statement.

In 1974, when we first did this profit statement, we calculated that our students, through taxes paid, had returned over $89,000 to the Federal Government just in Federal taxes paid.

In 1979, that profit figure had escalated to $3,800,000. And we did project that by 1984, in 15 years, that profit figure would go to over $19 million.

Now, we all know we have got a tough economy, and we know that employment is tough, so that 1984 figure we might have to look at, but I am happy to tell you today that graduates of this school, St. Paul TVI, both hearing graduates and deaf graduates, even though we are not maintaining the same placement rate of past years, we are catching up.

We are at about the 75-percent job placement level for the most recent graduating class. Normally, we would be at 95 percent. We are in there fighting for those jobs. We are very pleased that you recognize how serious our situation is in terms of being refunded.

I am sure that you are aware of the General Counsel opinion that was issued in 1978 which indicates that the Office of Special Education must have a message from the Congress prior to the expiration of the Education for the Handicapped Act that these funds be stipulated.

We feel very strongly about the need for that stipulated status, not to be a discretionary program, not to go into open competitive bidding, and the reason we feel that strongly is because of the charts that you see there.

There are kids out there that are going to need to be served. We feel that we have the support model in place to serve those students. That is my summary. I would like to introduce Mr. Opheim, unless you would like to do that, Mr. Chairman.

Mr. **Erdahl**. That is fine. Why don't you just proceed, Ed?

[The prepared statement of Robert Lauritsen follows:]

PREPARED STATEMENT OF ROBERT R. LAURITSEN, ST. PAUL TECHNICAL VOCATIONAL INSTITUTE FOR CALIFORNIA STATE UNIVERSITY AT NORTHRIDGE, DELGADO COLLEGE, AND SEATTLE COMMUNITY COLLEGE

HISTORICAL BACKGROUND AND STATEMENTS OF NEED

In the year 1864 the Congress enacted legislation establishing a collegiate institution soley for deaf persons. This legislation, signed into law by President Lincoln, created what is now known as Gallaudet College. In 1965 the Congress passed and President Johnson signed into law P.L. 89-36 establishing the National Institute for the Deaf. The Rochester Institute of Technology, Rochester, New York, won the competition for the host institution. In 1967 the Bureau of Education for the Handicapped and the Rehabilitation Services Administration jointly created the opportunity for unmet education needs of deaf persons by providing for three regional post-secondary programs. These programs, which began operation in 1968-69, were located at Delgado Junior College, New Orleans; Seattle Community College; and the St. Paul Techrical Vocational Institute (TVI). The success of these three programs in mainstreaming students in institutions that historically served hearing students brought about passage of Section 625 of the Education of the Handicapped Act, P.L. 91-230, as ammended in 1974, which established regional education programs for deaf and other handicapped post-secondary students. In 1964 California State University at Northridge initiated several post-secondary programs in the field of Deafness. The California programs were funded under a variety of private, state, and federal resources. Three programs were initially funded under Section 625. They were California State University at Northridge, Seattle Community College, and St. Paul TVI. Delgado College was added as a fourth stipulated program in 1975. These four programs have retained stipulated status since 1975.

Gallaudet College, the National Technical Institute for the Deaf, and the four Regional Education Programs comprise the six federally funded post-secondary programs for deaf persons that exist in 1982.

The stipulated status of the four Regional Education Programs is in serious jeopardy. A United States General Consul opinion written in 1978 states that the stipulated status of the four programs would expire at the normal expiration phase of the Education of the Handicapped Act unless Congress sent the message that stipulated status should be retained. The timely passage into law of H.R. 6820, Title III is critical if deaf persons are to continue receiving comprehensive support services in established programs and if the original intent of Section 625 is to be served.

Title III of H.R. 6820 presents the following five findings:

"1) deafness is a major learning handicap and there is a great need for post-secondary educational programs to assist deaf individuals in attaining the highest possible level of development;

2) deaf individuals have a right to participate in post-secondary education;

3) deafness is a low-incidence handicap, and this national constituency is most appropriately served by the existing four regional education programs;

4) the success of deaf students enrolled in the four regional education programs is cost effective and profitmaking when a comparison is made of federal income taxes paid with the federal funds invested to provide career training; and

5) it is in the national interest to continue to provide support for the four regional education programs and other institutions of higher education and appropriate non-profit agencies, and it is the proper function of the federal government to provide such support."

The four stipulated Regional Education Programs strongly agree with these statements. We further believe there are compelling factors which support these findings and why the stipulated status of the four Regional Education Programs should be retained. The following statements delineate the needs for stipulated status.

Statement One:	The need for stipulated programs for deaf persons has never been greater because of the Rubella Bubble.
Statement Two:	The four existing Regional Education Programs have support service systems in place.
Statement Three:	The four existing Regional Education Programs have demonstrated cost-effectiveness.
Statement Four:	The four Regional Education Programs serve the national interest.

STATEMENT ONE: The need for stipulated Programs for Deaf Persons has never been greater because of the Rubella Bubble.

A rubella epidemic swept the United States in the mid-sixties. The infants who were impacted by rubella in the mid-sixties are becoming the adults of the 1980's. There will be more young adults who are deaf than at any time in history when the normal incidence of deafness is added to rubella deafened individuals.

In the Spring of 1982, St. Paul TVI conducted a survey of residential schools and day schools in the upper midwest states. Five sets of information were asked for and received:

1) Number of deaf and hard of hearing graduates for the years 1982-1986.
2) Numbers of graduates expected to seek post-secondary education at two year post-secondary institutions.
3) Number of graduates expected to seek post-secondary education at the baccalaurate level.
4) Total number of graduates expected to seek post-secondary education both at the two-year and four-year level (add 2 and 3).
5) Total number of all graduates seeking post-secondary education that will require specialized education as offered by the six federally funded post-secondary programs for the deaf; i.e. Gallaudet College, the National Technical Institute for the Deaf, St. Paul TVI, Seattle Community College, California State University at Northridge, and Delgado College, New Orleans.

Actual head-count data was received from ten residential schools for the deaf and from twenty day school classes and programs for the deaf. Using the data obtained, projections were made to obtain national data for sixty residential schools for the deaf and 330 day school classes and programs for the deaf. The results of the national projections are shown in Chart I.

CHART I

Number of Deaf and Hard Of Hearing Graduates

	1982	1983	1984	1985	1986	TOTAL
Projected	3679	6968	6721	5655	3952	26,975

Estimated Number of Graduates that will seek Post-Secondary Education at Less than the Baccalaureate Level

	1982	1983	1984	1985	1986	TOTAL
Projected	2652	4264	5005	3419	1807	17,147

Estimated Number of Graduates that will seek Post-Secondary Education at the Baccalaureate Level

	1982	1983	1984	1985	1986	TOTAL
Projected	949	1742	1365	1209	728	5,993

Estimated Number of Graduates that will seek Post-Secondary Education at both Less than the Baccalaureate Level and Education at the Baccalaureate Level

	1982	1983	1984	1985	1986	TOTAL
Projected	3185	5993	6357	4485	3120	23,140

Estimated Number of all graduates seeking Post-Secondary Education that will require either the Educational Model of Gallaudet College or NTID or one or more Supportive Services of the St. Paul TVI Model in order to have a successful Post-Secondary Education Experience. Note: Supportive Services include: (1) Preparatory Program or Special Orientation (2) Counseling (3) Interpreting - oral or manual (4) Notetaking (5) Tutoring (6) Auditory Training (7) Specialized Media (8) Socialization/Recreation Programs.

	1982	1983	1984	1985	1986	TOTAL
Projected	2457	4745	4888	3510	1963	17,563

Five summary statements were elicited from Chart I. These statements are:

- The Rubella Bubble is dramatic for 1983, 1984, and 1985.
- 63% of deaf and hard of hearing graduates will seek post-secondary education in two year programs.
- 22% of deaf and hard of hearing graduates will seek post-secondary education at the baccalaureate level.
- 86% of deaf and hard of hearing graduates will seek post-secondary education at either the two-year or four-year level.
- 75% of all deaf and hard of hearing graduates going onto post-secondary education will require specialized education and/or support services.

The numbers of graduates for the years 1982-1986 are show in graph form in Figure I. The numbers closely parallel birth rate numbers that were obtained in earlier years by the Office of Demographic Studies of Gallaudet College. The Gallaudet figures are shown in Figure II.

Figure I

Projected Number of Deaf and Hard of Hearing Graduates

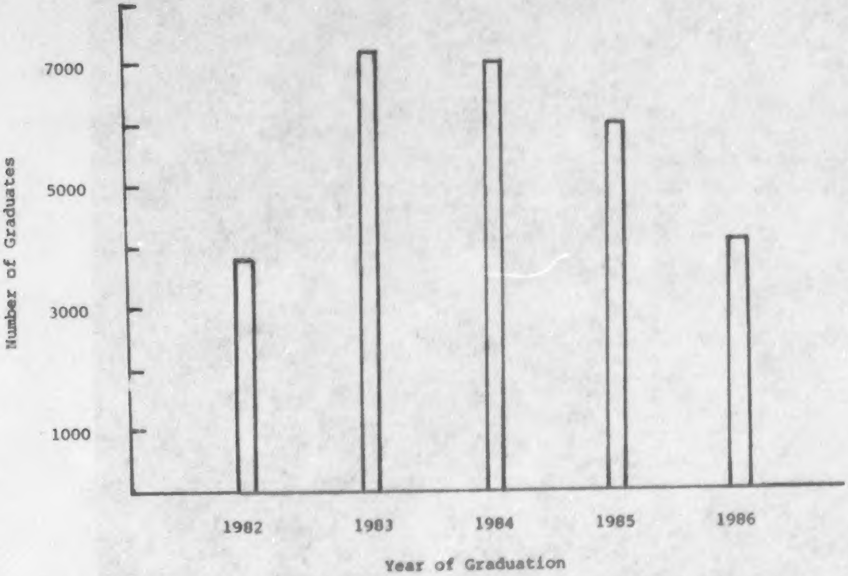
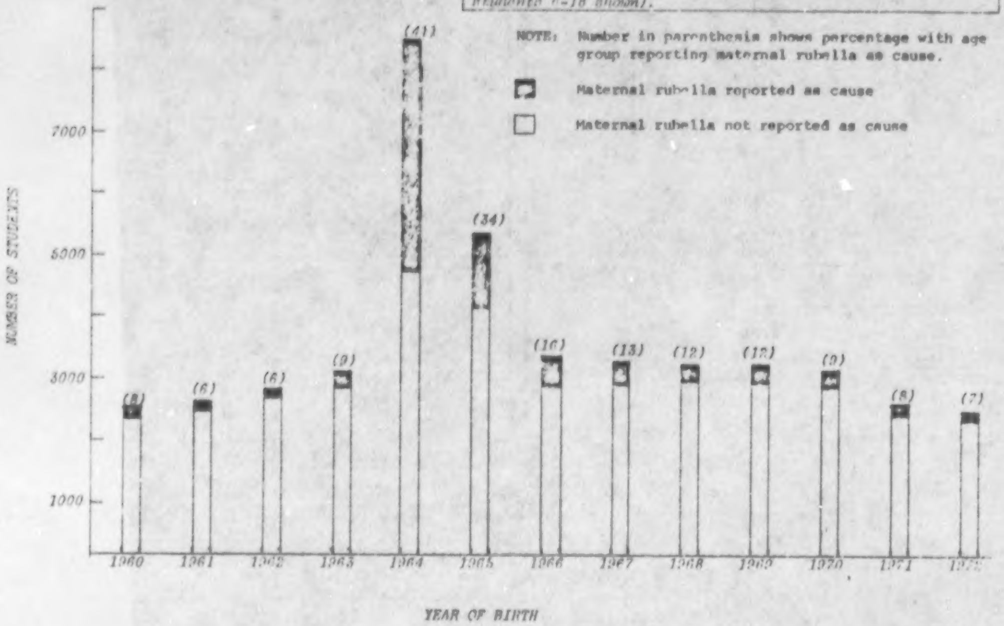


FIGURE II

Hearing Impaired Students in Special Education reported to the annual survey of hearing impaired children and youth, 1978-79, by year of birth and according to whether maternal rubella was reported as the cause of hearing loss (only students 6-18 shown).

CHART VI



NOTE: Number in parenthesis shows percentage with age group reporting maternal rubella as cause.

OFFICE OF DEMOGRAPHIC STUDIES - GALLAUDET COLLEGE

BEST COPY AVAILABLE

It is known that rubella affects the fetus during pregnancy and that approximately 40% of children born of a rubella mother have additional handicaps. St. Paul TVI determined to select a typical residential school for the deaf and to obtain a class profile for one graduating class of 1983. The Iowa School for the Deaf, Council Bluffs, Iowa, was chosen as a representative school.

The purpose of the Class Profile was to provide one sample of a typical residential school graduating class and to project from that profile the kinds of program modifications that post-secondary education programs will need to make to accomodate deaf students in the mid 1980's. The Iowa Class Profile is felt to fairly represent graduating classes across the United States for the years 1983-1985. The Class Profile obtained is as follows.

SENIOR CLASS PROFILE

The following class profile is representative of a typical 1982-83 senior class at a midwestern residential school for the deaf. The class is larger than most senior classes. This is generally attributed to the rubella epidemic of the middle 60's. The percentage breakdowns, however, should approximate a representative figure. The profile will indicate the programmatic considerations that must occur for a school to fully meet the individual needs of each student. The profile may further shed light on possible post-secondary considerations for these students as they prepare to enter the world of work.

The class is comprised of sixty-two students, 32 boys and 30 girls. Seven (11%) reside at home and commute to school daily. Thirteen (21%) have attended the school less than five years. The students, like students everywhere, come in all shapes and sizes, displaying various skills, talents, and interests. However, all attend the school because they share a common hearing loss which demands special instructional arrangements.

Because students do vary, the instructional program at the school must be flexible. During the past year, nine students (15%) identified as gifted have been placed part-time in an integrated public school setting; six students, identified as low functioning, have been placed in special community oriented programs. In addition, many students possess additional handicapping conditions which may or may not have instructional or vocational implications, including: 4 (6%) legally

> *blind, 2 (2%) diabetic, 2 (2%) cerebral palsy, 2 (2%) emotional/behavioral problems, 1 (2%) epileptic, and 1% orthopedic.*
>
> *The true handicap of deafness is best observed in the language/reading classroom. Here the true handicap of deafness is manifested. In this class of sixty-two, five students (8%) have reading levels greater than a 10.0 grade level; seven (11%) have composite test scores higher than a 10.0 level. Twenty-eight (45%) have reading levels lower than a 4.0 grade level; twenty-two (35%) have composite test scores lower than a 4.0 reading level. Reading levels must, however, be interpreted within the context of the handicap. It is not indicative of intelligence or ability.*
>
> *While it is estimated that up to fifteen students could be candidates to attend Gallaudet College upon graduation, it is expected that no more than seven (11%) will elect to do so. It is expected that a minimum of another twenty-five (40%) will attend a vocational/community college with appropriate support services for the deaf.*
>
> *As a concluding statement, this class, like its predecessors, has the ability to assume a responsible role in society. Class members, without exception, given the proper training and opportunities, can become contributing members of society.*

Parents of rubella children of the 1960's (predominantly hearing parents) are extremely concerned about post-secondary education opportunities for their children. St. Paul TVI is receiving an increasing number of requests for information and reservations for deaf children who will be leaving secondary schools in 1983 and 1984. These advance requests are without precendent in the history of the Program for Deaf Students. Letters are on hand from Colorado (4), Florida (4), Hawaii (2), Illinois (2), Iowa (4), Montana (2), New Jersey (4), New York (4), Pennsylvania (3), West Virginia and Wisconsin. Phone calls are being received from across the United States in increasing numbers from parents, secondary schools, and rehabilitation workers requesting information for the 1983-84, and 1984-85 academic years. Since March 1982 there have been parent visitations from Colorado, Illinois, Indiana, Nebraska, North Dakota, Pennsylvania, Wisconsin, the District of Columbia, and Canada. Visitations were also received from Africa, England, Iceland, Norway, and Poland.

The concern of the rubella individuals is a family concern. The typical family lacks resources to deaf with rubella. Families are looking to the four existing Regional Education Programs for assistance.

It is emphasized that the numbers of young deaf adults graduating from secondary schools from 1983-1985 will be the largest number of deaf school graduates in history. St. Paul TVI is prepared to make programmatic changes in courses of study to accomodate the Rubella Bubble and those persons who may have extraordinary education needs. These programmatic changes include extended preparatory studies, developmental or readiness programs, extended courses of career study, computer assisted intruction, spin-off programs, and combined day/evening diploma programs. St. Paul TVI has served students from the leading edge of the Rubella Bubble, and in addition to program modification, it is known that select students will need more one-on-one intensive education than the typical deaf student. For example, individuals who have combined hearing and visual problems will need highly individualized support services. What needs to be done is to initiate even more specialized support systems than presently exist so that these young adults can receive education that will better prepare them for life.

STATEMENT TWO: The four existing Regional Education Programs have Support Service Systems in place.

The Congressional Statement of Findings for H.R. 6820, Title III, states in part (1) "deafness is a major learning handicap and there is a great need for post-secondary educational programs to assist deaf individuals in attaining the highest possible level of development; and part (5) "it is in the national interest to continue to provide support for the four Regional Education Programs ..."

The Regional Education Programs have been in existence since the 1960's. Each of the four programs have developed a support service system for deaf students. These systems permit deaf students to matriculate in institutions that historically served only hearing students.

The St. Paul TVI support service model will be described. The support service model systems at California State University at Northridge, Delgado College, and Seattle Community College are highly similar. Slight differences in the model exist because of host institution differences.

The support service model is designed to counteract and compensate for the learning handicaps imposed by deafness. It is stated that the education of the deaf is the most special of all areas of special education. Further, the major problem in educating deaf children is teaching deaf persons to process language. If a person cannot hear, how is language learn? If language is not readily learned, how is reading, spelling, and arithmetic learned? How is career information learned? Language is at the root of both formal and informal education. The support service model deals directly with the deaf person's langauge and the inability to hear. The major emphasis of the Regional Education Programs is to minimize language and communication barriers in assisting to prepare deaf individuals for careers and self-sufficiency in the adult world, and the majority world which is the hearing world.

The support service model in place at St. Paul TVI has well defined major components. Capsule descriptions of this model are as follows:

PREPARATORY PROGRAM - The Preparatory Program is a one-quarter program designed to assist students in making the transition to living independently in the community; to adjust to studies in a hearing environment; to select a career area of study; and to do remedial readiness training for competetive study in a hearing environment.

COUNSELING - Counseling services are the all pervasive area of support service that provide individual and group assistance in students' coping independently. Counseling services are available as part of the admissions process, during matriculation, and after completion of a course of study.

FINANCIAL ASSISTANCE - Financial aid packaging is a major priority in today's economy. Students are provided assistance in putting together financial aid packages so that post-secondary education can be affordable.

INTERPRETING - Interpreters provide the communication link between deaf persons and hearing persons. Interpreting is most often by use of a sign language system, although interpreting may be oral. Interpreting is primarily an education function, though some telephone interpreting is done (calling home when home has no TTY), and interpreting is provided for job seeking and work orientation.

NOTETAKING - Skilled notetakers provide lecture notes, often with drawings, graphs, and charts at appropriate language levels for deaf students.

TUTORING - Interpreters and notetakers plus select other persons provide tutoring services. Tutoring assists students in acquiring needed background information, mastering new concepts, and new vocabulary.

AUDITORY TRAINING - Auditory Training, or speech and hearing services, assist students to maximize use of residual hearing, improve lip-reading, correct speech, and maximize use of hearing aids.

CONSORTIUM PROGRAMS - Select students may matriculate at cooperating neighboring schools when their choice of major is not available at St. Paul TVI. Consortium services provide in-service training for consortium school staff, insure the provision of support services in the consortium school, and provide itinerant counseling.

CONTINUING EDUCATION - Continuing Education, or Extension Education, allows students to participate in evening studies either as a part of their regular day school program, as required; or elective or mandatory study upon completion of a full-time program of study.

JOB PLACEMENT AND FOLLOW-UP - Students are provided training in job-seeking skills, preparation of resumes, interpreting services, and counseling for job placement. Cooperative working relationships are in place with Job Services and Projects With Industry.

INTERPRETER TRAINING PROGRAM - Interpreter Training Programs are maintained to insure a continuing supply of well trained interpreters.

EXTRA-CURRICULAR PROGRAMS - Extra-curricular programs provide students leadership in drama club activities and use of leisure time.

PUBLIC AWARENESS PROGRAMS - Program staff members are continuously called on to provide public awareness training programs. The general public including schools, churches, state and federal government, and the private sectors are requesting public awareness information on Deafness.

The support service model described is a relatively complete yet minimum model because of financial constraints. For calendar year 1982, the TVI model has several sources of funding. The federal dollars under Section 625 of the Education of the Handicapped Act are $631,880. Separate federal funds in the amount of $94,850 are in place for the training of interpreters. The State of Minnesota, Department of Education, Technical-Vocational Division, provides in excess of $300,000 additional dollars for the Preparatory Program, Consortium Programs, Interpreter Training, Sign Language Studies, and Continuing Education for Deaf Adults. Federal dollars and state dollars currently available to serve deaf students exceeds $931,000 annually. The federal funds serve as the base of the funding pyramid.

The costs for the support service model are excess costs over and above the regular costs of technical-vocational education.

STATEMENT THREE: The four existing Regional Education Program have demonstrated cost-effectiveness.

The four Regional Education Programs function in institutions that historically served only hearing persons. The physical plant costs and operating budgets of the four host institutions for 1981 exceeded $835,000,000. In 1982, the four Regional Education Programs will expend approximately $2,200,000 to serve in excess of 750 full time deaf students and in excess of 4,500 deaf persons and hearing persons in short-term training programs. The $2,200,000 of federal funding buys full access into each of the host institutions. This is one measure of cost effectiveness.

A second measure of cost-effectiveness is to look at the excess costs that are required to provide post-secondary education for a deaf student, and to compare this cost to the length of time that a graduate needs to be employed to pay a sufficient amount of federal taxes to equal the excess cost for the training received. Minimal annual average salaries for graduates of St. Paul TVI in 1981, when economic times were better, for both hearing and deaf graduates were: general office worker - $10,080; accountant - $10,730; graphic arts - $12,480; cabinetmaker - $13,000; machinist - $14,145; welder - $14,770. Figures obtained from the Internal Revenue Service indicate that for a single person the taxes paid for workers would range from $1,900 to $3,397, and for a married person from $1,600 to $2,806. An average excess cost per student equals approximately $2,600 a year. The majority of graduates will pay federal taxes to match their individual excess cost of training in about the same number of months on the job as the number of months they were in training. The average length of a training program is just under two years.

Chart II is a profit statement that shows the number of graduates in five year increments, earnings of these graduates, federal taxes paid on those earnings, federal dollars to provide training, and the differential in dollars between the federal investment and federal taxes paid. This chart is based on information at St. Paul TVI. These figures were generated in 1981 when unemployment was not as high as today. The chart shows a profit at the end of five years (1969-1974) of $89,000; a profit at the end of ten years (1974-1979) of $3,837,567; and a projected profit (1979-1984) of $19,347,327. Because there are four Regional Education Programs, the $19,347,327 figure could be multipled by four or $77,389,308 for an approximation of the profit-making aspect of the Regional Education Programs.

Chart II

ST. PAUL TVI
PROFIT STATEMENT

	1974	1979	1984 Projected
Number of Grads	225	579	1,054
Earnings	$3,570,000	$21,183,240	$85,382,440
Federal Tax	856,800	6,354,972	25,614,732
Federal $ to Provide Training	767,000	2,517,405	6,267,405
"PROFIT"	89,800	3,837,567	19,347,327
% of Return	8½%	152%	308%

THESE FIGURES DO NOT INCLUDE NON-GRADS, MANY OF WHICH RECEIVED SUBSTANTIAL TRAINING AND ARE WELL EMPLOYED.

For the 1979 figures it is estimated there are an additional 130 individuals who matriculated at St. Paul TVI that did not graduate but who are gainfully employed. We also estimate there are 130 individuals who matriculated at TVI that are homemakers, unemployed, continuing education or seeking jobs.

Chart III is a loss statement illustrating at a minimum the loss in dollars should St. Paul TVI not have deaf graduates for the five years 1979-1984. This chart is based on 95 graduates a year for five years, representing the national average for single and married persons, and uses minimum figures for welfare dependency for Ramsey County, St. Paul, Minnesota. The chart projects welfare costs for the four Regional Education Programs. The worst possible option illustrated shows a loss of $33,667,152.

Combining the profit figure of $77,389,308 and the maximum loss figure of $33,667,152 yields a total impact figure in excess of $110,000,000.

The concept of critical mass has long been felt by educators of the deaf to be an essential element of programs serving deaf students. Critical mass is defined as:

> ... a minimum number of students to form a cohesive peer group that permits individual differences to prevail in developing adequate interpersonal relationships within the peer group; the development and confidence of self in the peer group to compete adequately in the larger academic and social environment, the hearing environment. The precise minimum number of like students to form a critical mass will vary from program to program and will be directly dependent upon the size of the host institution.

The Statement of Findings of H.R., Title III states in Section 3, "deafness is a low incidence handicap and this national constituency is most appropriately served by the existing four Regional Education Programs.

Since the beginnings of the Regional Education Programs in the 1960's, there have been 3,500 students served. These students represent every state in the United States, the District of Columbia, Canada, the territories of the United States, and 63 students from foreign countries. Federal funding permits the four Regional Education Programs to serve large

Chart III

LOSS STATEMENT
WELFARE COSTS FOR 475 NON-STUDENTS
1979 - 1983

YEAR	ACCUMULATED NO. OF GRADS	TOTAL PROJECTED COSTS FOR ALL GRADUATES Monthly	Annually		
1979	95	$ 42,092	$ 505,104	$ 8,416,788	Projected welfare costs for 475 individuals for one regional education program.
1980	190	86,279	1,035,348	33,667,152	Projected welfare costs for 1900 individuals for four Regional Education Programs.
1981	285	135,875	1,630,500	6,312,591	Projected welfare costs for 356 individuals (75%) for one Regional Education Program.
1982	380	190,023	2,280,276	25,250,364	Projected welfare costs for 1424 individuals (75%) for four Regional Education Programs.
1983	475	247,130	2,965,560	4,208,394	Projected welfare costs for 237 individuals (50%) for one Regional Education Program.
5 Year Total		$701,399	$8,416,788	$16,833,576	Projected welfare costs for 948 individuals (50%) for four Regional Education Programs.

PERSONS THAT ARE EMPLOYED WITHOUT POST-SECONDARY TRAINING TEND TO BE UNDEREMPLOYED geographic areas and thereby to attract sufficient numbers of students to maintain deaf student populations that comprise a critical mass. In good economic times the State of Minnesota would not pay excess costs for students from other states. It would be unthinkable that Minnesota would pay excess costs for students from other states in the present economy. The State of Minnesota, like most states, does not have a sufficiently large number of students to comprise a critical mass of students. Since the inception of the Program for Deaf Students at St. Paul TVI in 1969, Minnesota students have comprised 26 percent of the student body on any given day. Based on an average daily membership of 150 students from throughout the United States, the average number of Minnesota students is 39 students in residence. Thirty-nine students do not comprise a critical mass of students. Financially it would not be possible because of high cost to maintain a comprehensive program of support services for 39 deaf students. What could be offered would be a watered down support service system that would result in a watered down education.

The current high unemployment rate of the United States and the general state of the economy only serve to increase the urgency of strong, regional post-secondary education programs for deaf students. It is said that "if you think education is expensive, try ignorance." Deaf people, like hearing people, need education. For deaf people to acquire education, the education must be special. The four Regional Education Programs have proven, established records of being cost-effective and programs that work.

STATEMENT FOUR: The four Regional Education Programs serve the national interest.

The over-whelming majority of students served in the four Regional Education Programs are pre-lingual deaf persons (persons who lost their hearing before acquiring language). Deafness does not recognize economic status, ethnic background, age, or any other human factor. Deafness can strike in a number of ways and at different times in life. The following story illustrates one person's encounter with deafness; a person whose hearing loss occurred later in life.

> In 1964 Richard Gebo was stationed in Iceland serving as a jet machanic in the United States Air Force. He was stricken with a sudden and complete loss of hearing. After extensive examinations and treatment in military hospitals, he was released and returned to his home in Great Falls, Montana, where he found employment as a service repairman.
>
> In 1969 he enrolled at Seattle Community College where he learned there was a special program which provided interpreting and other services for deaf students. He completed his AA degree in 1971. While at the community college his counselors recognized his potential and encouraged him to continue his education at California State University at Northridge, which also offered support services for deaf students. He enrolled in the fall of 1971 and completed his bachelors degree with a major in Psychology in 1973.
>
> In the fall of 1973 he was admitted as a graduate student in the department of Special Education and in 1974 completed requirements for his teacher of the deaf credential and a masters degree. Following graduation, he was employed as a teacher of the deaf at the Montana School for the Deaf where he now serves as dean of students.
>
> He applied for the National Leadership Training Program at California State University and was accepted as a participant in the class of 1982. On August 11 he received his NLTP certificate and his masters degree in Educational Administration and Supervision.
>
> Yes, it has been a long distance from Iceland to Great Falls, Montana, but along the way Richard Gebo has earned an AA degree from Seattle Community College, and three degrees from California State University at Northridge (a bachelors degree and two masters degrees); but Richard Gebo

> is still on the move. He looks foward to becoming a superintendent or principal or a day or residential school for the deaf where he can apply his personal experience and education to provide quality education for deaf students.

Richard, as several thousands of Deaf Americans, is making his way in life because of Regional Education Programs. As we move through the 1980's there will be an unprecedented number of Deaf Americans who will be seeking post-secondary education programs that are designed to meet their specialized education needs. Deaf people are mobile people. Deaf people seek out post-secondary education programs that provide (1) strong support services, (2) a concentration, or critical mass of other deaf people, and (3) training programs that lead to jobs. The four federally funded stipulated programs have provided these three basic needs for deaf people since the 1960's. The four Regional Education Programs provide education in hearing environments and in institutions that are responsive to the employment needs of the community. The four Regional Education Programs offer technical-vocational education, community college education, and university level education. The concentration of federal dollars in four established regional programs permits the provision of meaningful support service systems that serve targeted populations. Deaf people in the United States have these regional programs to acquire and maintain skills that are essential for survival in the marketplace. The need will be even greater as we move through the 1980's.

STATEMENT OF ED OPHEIM, DIRECTOR, MINNESOTA VOCATIONAL REHABILITATION

Mr. OPHEIM. Mr. Chairman and Senator Boschwitz, we are honored that you have chosen this facility in our State for this initial hearing on H.R. 6820. On behalf of the Minnesota Department of Economic Security and the division of vocational rehabilitation, I welcome you and I also thank you, Mr. Chairman, for not relating those stories about Bob and me and our days at school.

My name is Edwin Opheim, the assistant commissioner for the division of vocational rehabilitation [DVR] of the Minnesota Department of Economic Security.

My testimony will be directed specifically toward the benefits received from and the need for the continuation of regional postsecondary education programs for the deaf. I will omit portions of my prepared testimony at this time and submit the full text for the record.

One measure of success for the rehabilitation of disabled persons is the ability of a program to interface with a variety of systems and cooperate in the use of resources. The program that we have here at the St. Paul AVTI has demonstrated the benefits to be gained from this kind of an interface. They have effectively utilized State, Federal, and local fiscal resources in order to provide for the specialized needs of hearing impaired students.

But more importantly, the program has made it possible for hearing impaired students to expand their scholastic and personal goals and to have a wider choice of career opportunities. In order to be effective a human service program must recognize and respond to emerging needs with a need for training. The St. Paul AVTI created a program to train interpreters for the deaf. Because of this program deaf individuals with hearing disabilities are able to participate in the mainstream activities of the community. It is gratifying to see interpreters at public meetings all over Minnesota, on television, at legislative hearings and have them available for the individual needs of hearing impaired persons.

With the resources made available, through innovation and expansion grant funds, St. Paul ATVI has developed training materials that are widely used by other professionals throughout the country. These include development of a series of films for use with "montron" equipment to help interpreters maintain their skills. These films are used nationally and are available through the National Association for the Deaf. We also produced a 29-minute film on the modification of job seeking skills training for persons with hearing impairments. This is also available through the National Association for the Deaf.

We have developed training materials for people on medical sign language. This program has increased awareness of the special communication needs of the hearing impaired. In vocational rehabilitation the primary consideration is how to increase the likelihood of vocational success. In addition to the social and economic benefits to the individual and his or her family, successful vocational performance returns substantial benefits to the Nation's economy. We recently completed a cost benefit study which shows that all costs of vocational rehabilitating a person with a hearing disability are repaid in less than 4 years through payment of taxes and decreased reliance on public assistance.

For every dollar spent on a hearing impaired vocational rehabilitation program, that individual will increase earnings an average of $9.20. The study indicates that the payback is an average of less than 3 years with an average increase in earnings of $11.44, attributable to the rehabilitation process. Because of special communications needs and other necessary adaptive skill training, rehabilitation costs for hearing impaired persons are somewhat higher than for the handicapped person in general.

Modern training combined with high quality communication skills provides the greatest likelihood of successful placement. Without resources which are geared to state-of-the-art training in demand occupations, there is little opportunity for the hearing impaired persons to realize their vocational potential. The success of the St. Paul regional postsecondary education program clearly demonstrates the value of services for hearing impaired persons and the need for continuation of the program.

Services are needed for a large and growing population of hearing impaired individuals in Minnesota. Approximately 93,000 or 17 percent of Minnesota citizens have a serious hearing loss. While not all are in need of vocational rehabilitation because of age and other factors, a substantial number are of working age, approximately 50 percent of that number.

One problem of significance are the individuals who are hearing impaired as a result of the mid-1960's rubella epidemic. These individuals may have received training in residential schools, day classes and in other special education programs. They are now at the age where vocational training, preparation for working and living in a community must be provided not to prolong dependence on public assistance. Information on chart 3 shows that there are approximately 27,000 persons at this point in time who will be needing vocational rehabilitation services in the very near future.

Regional postsecondary education programs provide the most cost effective method and the highest quality training possible. By bringing together a group of students who have similar special needs, a professional staff can be trained and made available to serve them with a minimum amount of duplication. We are in an increasingly technology society. It is imperative that vocational training programs for the handicapped provide the latest advances needed for placement in industry.

The programs for the hearing impaired assure that students are taught the full range of necessary skills. For handicapped students trained in their own communities or special schools, this is the logical next step to lead to social independence for the hearing impaired. The services of technical assistance provided to the regional postsecondary education program at St. Paul ATVI are essential to the public and private agencies working together to improve the lifestyle and the career possibilities of hearing impaired individuals.

We believe that the benefits of this program can be demonstrated in tangible and nontangible measures. We believe that the need for continuation of the program is adequately documented by the number of hearing impaired persons who will be needing preparation for work. It is our hope that this subcommittee will act favorably in continuing funding for postsecondary education programs.

I want to express my appreciation to the members of the committee and to the author of H.R. 6820, Congressman Erdahl, for continuing help for education of handicapped persons.

[The prepared statement of Edwin Opheim follows:]

PREPARED STATEMENT OF EDWIN O. OPHEIM, DIRECTOR, MINNESOTA VOCATIONAL REHABILITATION PROGRAM

MR. CHAIRMAN AND DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE ON SELECT EDUCATION:

Welcome to Minnesota.

We are honored that you have chosen this facility and our state for the initial hearing on H.R. 6820. We hope that you have had an opportunity to see first-hand the results programs such as this have in bringing about an opportunity for independence and greater dignity for persons who are disabled.

My name is Edwin Opheim, the Assistant Commissioner for the Division of Vocational Rehabilitation (DVR) of the Minnesota Department of Economic Security.

My testimony will be directly specifically toward the benefits received from and the need for the continuation of Regional Post-Secondary Education Programs for the deaf.

To be successful in the rehabilitation of disabled persons, a program must interface with a variety of service delivery systems and cooperate in the use of all resources. The program at the St. Paul Area Vocational Technical Institute (AVTI) has demonstrated the benefits to be gained from successful partnerships.

- State, federal and local fiscal resources have been utilized to provide for the specialized needs of hearing impaired students. Language and communication barriers have been minimized so that many students are able to attend programs which have not traditionally served deaf persons.
- Strong, productive cooperative efforts among education, rehabilitation, advocacy groups, industry and labor organizations have made it possible for hearing impaired students to have expanded scholastic and personal goals and a wider choice of career opportunities.

In order to remain viable, a human service program must recognize and respond to emerging needs. When the need for training interpreters was recognized, the St. Paul AVTI created a program to train interpreters for the deaf. Because of this program, individuals with hearing disabilities are able to participate in the mainstream activities of the community. It is gratifying to see interpreters at public meetings all over Minnesota, on television, at legislative hearings, and available for the individual needs of hearing impaired persons.

With resources made available through innovation and expansion grant funds, St. Paul AVTI also developed training materials that are widely used by other professionals throughout the country. These include:

- Development of a series of films for use with "montron" equipment to help interpreters maintain their skills. These films are used nationally and are available through the National Association for the Deaf.
- Production of a twenty-nine minute film on modification of job-seeking skills training for persons with hearing impairments. This is also available through the National Association for the Deaf.
- Training materials and information for physicians, nurses, hospital staff, interpreters, Division of Vocational Rehabilitation (DVR) counselors, and others on medical sign language. This program has increased awareness of special communication needs of the hearing impaired and has resulted in better access to medical and health care systems.

In Vocational Rehabilitation, a primary consideration is how to increase the likelihood of vocational success.

In addition to the obvious social and economic benefits to the individual and his/her family, successful vocational performance returns substantial benefit to the nation's economy.

The Minnesota Division of Vocational Rehabilitation (DVR) recently completed a cost-benefit study which shows that all costs of vocationally rehabilitating a person with a hearing disability are repaid in 3.68 years through the payment of taxes and decreased reliance on public assistance. For every $1 spent on a hearing impaired individual's rehabilitation program, that individual will have an average earnings gain of $9.20. (An executive summary of this cost-benefit study is attached as appendix 'A'.)

The costs of rehabilitation used in the study are the total costs of the Vocational Rehabilitation programs for the fiscal year of interest and the actual case service expenditures for rehabilitants of that year. This included the case service costs for these rehabilitants which may have occurred in prior years. Agency-wide statistics indicate the payback for all agency clients is an average of 2.87 years, with an average earnings gain of $11.44. The average rehabilitation cost for all agency clients is $3,348.07 as compared with $3,855.89 for hearing impaired clients. Because of special communication needs and other necessary adaptive skill training, rehabilitation costs for hearing impaired persons are somewhat higher than for the handicapped population in general. Modern vocational training combined with high quality communication skills provides the greatest likelihood of successful placement and employment retention. Without resources which are geared to "state of the art" training in demand occupations there is little opportunity for hearing impaired persons to realize their vocational potential.

The success of the St. Paul Regional Post-Secondary Education Program clearly demonstrates both the value of services for hearing impaired persons and the need for continuation of the program. Services are needed for a large and growing population of hearing impaired individuals in Minnesota and in the nation.

Specifically, the incidence of disabilities in Minnesota, including hearing impairment, is well established as a result of research conducted by the Minnesota Division of Vocational Rehabilitation (DVR). The findings of this research appeared in Assessment of Disability in Minnesota authored by Han Chin Liu, Ph.D. of the Minnesota Division of Vocational Rehabilitation and Eugene Perkins, Ed.D. of St. Cloud State University, published in 1978. (A copy of this study is attached as appendix 'B'.)

That study found that 93,096 or 17.9 percent of Minnesota's citizens have a "serious hearing loss". While not all are in need of Vocational Rehabilitation because of age or other factors, a substantial number are of working age. Of special significance at the present time are the individuals who are hearing impaired as a result of the mid-sixties rubella epidemic. These individuals have been trained in residential schools, day classes, and other special education programs. They are now at the age when vocational training, preparation for work and living in the community must be provided to prevent prolonged dependence on public assistance. A recent national study showed that there were 26,975 such persons who will be needing vocational services in the very near future.

Regional Post-Secondary Educational Programs provide the most cost-effective method and highest quality training possible. By bringing together a group of students who have similar special needs, professional staff can be trained and available to serve them with a minimum amount of duplication. With an increasingly technological society, it is imperative that vocational training programs for the handicapped provide the latest advances needed for placement in industry.

The Regional Post-Secondary Education Programs for the hearing impaired assure that students are taught the full range of necessary skills. For handicapped students trained in their own communities or in special residential schools, this is the logical next step which eventually leads to economic and social independence for the hearing impaired.

The state of Minnesota has made a commitment to the goal of improving the services to hearing impaired persons. For example, in 1979 the Minnesota State Legislature, as part of the Hearing Impaired Services Act (HISA), authorized the establishment of up to 8 Regional Service Centers (RSCs) for the hearing impaired in Vocational Rehabilitation field offices around the state. The Regional Post-Secondary Education Program at St. Paul AVTI was an important partner in the development of these centers by providing technical support to DVR staff.

In summary, the services and technical assistance provided through the Regional Post-Secondary Education Program at St. Paul AVTI are essential to the public and private agencies working together to improve the lifestyle and the career possibilities for hearing impaired individuals. We believe that the benefits of this program can be demonstrated in both tangible and non-tangible measures. We further believe that the need for continuation of the program is adequately documented in the number of young hearing impaired persons who will be needing preparation for work. It is our hope that this subcommittee will act favorably in continuing funding for Regional Post-Secondary Education Programs.

Finally, I wish to express my appreciation to the members of this subcommittee, and particularly the author of H.R. 6820, Congressman Erdahl, for continued interest and support for services to handicapped persons.

APPENDIX A

Executive Summary
of
MINNESOTA DVR FY 1981 ECONOMIC ANALYSIS

A Modified Cost/Benefit Procedure

by

Han Chin Liu, Ph. D.

March 1982

Division of Vocational Rehabilitation

Minnesota Department of Economic Security

Executive Summary of Minnesota DVR FY 1981 Economic Analysis: A Modified Cost/Benefit Procedure

Introduction

The Minnesota Division of Vocational Rehabilitation adopted, with modifications, a conservative cost/benefit procedure developed by the Oregon Vocational Rehabilitation Division to analyze the economic impact of vocational rehabilitation[1]. The advantages of utilizing this procedure are:

(1) The procedure is a conservative cost/benefit model. It utilizes a series of adjustment factors to reduce gross earnings gain due to vocational rehabilitation. These factors include clients' possible unemployment in future, clients' mortality prior to retirement, underestimated clients' earning at referral, and earnings gain not attributable to vocational rehabilitation services.

(2) Costs in this model are computed on the individual client level, which enable program managers to analyze cost/benefit data for any grouping of disabled clients in order to increase program efficiency.

(3) The model is a computerized procedure which warrants data accuracy and manpower saving in the cost/benefit analysis. Because of its simplicity, program managers can conduct timely cost/benefit analyses to suit program needs.

The Costs of Rehabilitation

The costs of rehabilitation used in this model are the total costs of the vocational rehabilitation program for the fiscal year of interest, and the actual case service expenditures incurred in prior years for the rehabilitants of that year. Costs excluding cases service expenditures and some non-rehabilitation related costs are termed overhead costs. The overhead costs include expenditures for personnel and services related to the administration of the vocational rehabilitation program such as salary, rent, heat, lights, supplies, staff training, travel, contracts and grants.

This model allocates overhead costs to all closed cases (statuses 08, 26, 28, 30) proportional to the length of time they spent in the vocational rehabilitation process. Each individual client's share of overhead cost is computed. The vocational rehabilitation cost for an individual client is derived by adding his/her actual case expenditures to his/her share of overhead cost.

The average cost per rehabilitation is obtained by dividing the total costs for a given client group by its number of rehabilitants.

The Benefits of Rehabilitation

The benefits of rehabilitation designated by this model are client's earnings gain due to vocational rehabilitation. This earnings gain is the difference between client's referral earnings and earnings at closure. Clients' earnings at referral are adjusted for changes in wage rate over the period of time from referral to closure before computing the difference. The difference is then reduced to reflect the effects of the following factors on future earnings:

1. uncertainty (by discounting),
2. future short--term unemployment,
3. client mortality prior to retirement
4. referral earnings underestimation, and
5. gain not attributable to vocational rehabilitation services.

Fringe benefits are then added to the earnings gains to derive total client benefits.

Assumptions

1. The discount rate of 10 percent is used to derive an annuity discount factor to estimate the present value of future earnings. Since vocational rehabilitation's funding sources are governments, the use of the interest rate on government bonds is deemed appropriate.
2. The unemployment rate is assumed to be 4.53 percent, which is the average of the unemployment rates in Minnesota for the last three years.
3. The mortality factor is assumed to be 3.5 percent, adopted from the Oregon model.
4. The underestimate of earnings capacity at referral is assumed to be 39 percent, adopted from the Oregon model.
5. Gain not attributed to vocational rehabilitation is assumed to be 20 percent, recommended by RSA[2].
6. Fringe benefits are assumed to be 20 percent of the total monetary earnings suggested by the agency's accounting unit, which is more conservative than the rate of 23.3 percent reported by the U.S. Department of Labor[3].
7. The tax rate is assumed to be 20 percent, recommended by the West Virginia Rehabilitation Research and Training Center[3].
8. Homemakers and upaid family workers are assumed to have zero earnings.
9. Gains obtained by 28 or 30 closures are not considered in the computation of program benefits.
10. All non-monetary benefits of vocational rehabilitation programs are not assessed by this model because of lack of data.

Glossary

1. The client's income cost/benefit ratio is the ratio of discounted average future income gain to the average cost of rehabilitation. It is obtained by dividing the average discounted expected earnings gain by the average cost per rehabilitaiton. For Minnesota DVR in FY 81, this ratio was 11.44, implying that clients increased their earnings by $11.44 for every vocational rehabilitation dollar spent.
2. The average total client benefit is the average expected earnings gain discounted over the remaining working lifetime of the rehabilitated persons. On the average, each Minnesota rehabilitant of FY 81 was expected to have an additional earnings of $38,296.94, resulting from vocational rehabilitation, in his/her remaining working lifetime.

3. *The taxpayer's payback cost/benefit ratio* is the ratio of the *discounted average increase in taxes paid* and reduction in public assistance benefits to the average cost per rehabilitation. The tax rate used to calculate tax receipts is 20 percent of gross earnings for state and federal income taxes and social security withholding[4]. For Minnesota DVR in FY 81, this ratio was 3.32, suggesting that Minnesota DVR returned $3.32 to "the taxpayers" for every vocational rehabilitation dollar it spent.
4. *The taxpayer's net profit per rehabilitation* is that amount of money *over the costs of rehabilitation which will* accrue to the public through increased tax receipts and reduced public assistance payments over the remaining working lifetime of those rehabilitated. The estimated net profit for Minnesota taxpayers due to vocational rehabilitation in FY 81 was $7,758.25.
5. *The number of years required to repay cost* is obtained by dividing *the annual total cost of rehabilitation* by the annual total taxpayer's benefit, which is the combination of the annual increase in taxes and the annual reduction in public assistance. The result of analysis indicates that it would take 2.87 years for Minnesota DVR to repay the total rehabilitation cost it spent in FY 81.
6. *The annual rate of return* is a percentage rate of return which is *computed by taking 1 to be* divided by the number of years required to repay cost. The annual rate of return for Minnesota DVR in FY 81 was 34.8 percent.

Footnotes

1. Ross T. Moran, *A Client Level Economic Analysis of Oregon Vocational Rehabilitation* (Salem, Oregon: *Oregon Vocational Rehabilitation Division, June* 1980).
2. F.C. Collignor et. al. *Benefit/Cost Analysis of Vocational Rehabilitation Services Provided by the California Department of Rehabilitation* (Berkeley, California: Berkeley Planning Associates, 1977), p. IV - 9.
3. Bureau of Labor Statistics, U.S. Department of Labor, *Employee Compensation in the Private Nonfarm Economy, 1977* (April, 1980), *Summary* 80 - 5.
4. R.K. Majunder, et. al. *Benefit/Cost Analyses in Vocational Rehabilitation: A Simplified Approach* (Dunbar, West Virginia: West Virginia Rehabilitation Research and Training Center, 1978), p.5.

Table 1: Minnesota DVR FY 81 Economic Analysis by Client's SSI Status

SSI Status	Average Cost Per Rehab.	Client's Income Cost/Benefit Ratio	Average Total Client Benefit*	Taxpayer's Payback Cost/Benefit Ratio	Taxpayer's Net Profit* Per Rehabilitation	No. of Years Required to Repay Cost	Annual Rate of Return (%)
SSI Client	$4,227.59	4.02	$16,990.14	1.47	$1,999.06	6.47	15.5
Non-SSI Client	3,307.22	11.88	39,286.59	3.43	8,025.75	2.78	36.0
All Agency	3,348.07	11.44	38,296.94	3.32	7,758.25	2.67	34.8

Table 2: Minnesota DVR FY 81 Economic Analysis by Client's SSDI Status

SSDI Status	Average Cost Per Rehab.	Client's Income Cost/Benefit Ratio	Average Total Client Benefit*	Taxpayer's Payback Cost/Benefit Ratio	Taxpayer's Net Profit* Per Rehabilitation	No. of Years Required to Repay Cost	Annual Rate of Return (%)
SSDI Client	$3,415.31	6.84	$23,343.95	2.30	$4,429.25	4.15	24.1
Non-SSDI Client	3,344.46	11.69	39,101.76	3.37	7,937.42	2.82	35.5
All Agency	3,348.07	11.44	38,296.94	3.32	7,758.25	2.67	34.8

*Client and taxpayer monetary benefit, resulting from Vocational Rehabilitation over the remaining working life of the rehabilitated person, have been documented to estimate the present value of those future benefits.

Table 3: Minnesota DVR FY 81 Economic Analysis by Worker's Compensation Status

Workers' Comp. Status	Average Cost Per Rehab.	Client's Income Cost/Benefit Ratio	Average Total Client Benefit*	Taxpayer's Payback Cost/Benefit Ratio	Taxpayer's Net Profit* Per Rehabilitation	No. of Years Required to Repay Cost	Annual Rate of Return (%)
Workers' Comp. Client	$2,576.01	19.33	$49,803.06	5.03	$10,393.58	1.89	52.9
Non-Workers' Comp. Client	3,508.18	10.22	35,862.98	3.06	7,215.71	3.12	32.1
All** Agency	3,346.43	11.44	38,281.79	3.32	7,767.13	2.87	34.8

**Figures for all agency differ slightly from those shown in other tables because 18 cases did no have information on their workers' Compensation Status.

Table 4: Minnesota DVR FY 81 Economic Analysis by Referral Sources

Referral Source	Average Cost Per Rehab.	Client's Income Cost/Benefit Ratio	Average Total Client Benefit*	Taxpayer's Payback Cost/Benefit Ratio	Taxpayer's Net Profit* Per Rehabilitation	No. of Years Required to Repay Cost	Annual Rate of Return (%)
Education Institutions	$4,825.57	7.89	$38,059.34	1.60	$ 2,914.56	5.94	16.8
Hospital	2,623.58	14.59	38,274.03	3.44	6,389.28	2.77	36.1
Health Organization	3,195.96	10.51	33,586.46	4.24	10,346.48	2.25	44.4
Welfare	3,369.57	8.32	28,021.56	6.58	18,804.75	1.45	69.0
Public Organization	2,859.01	14.54	41,576.98	4.14	8,981.37	2.30	43.5
Private Organization	2,727.06	14.15	38,584.72	3.98	8,117.68	2.40	41.7
Individual	2,874.30	13.61	39,108.65	3.94	8,460.91	2.42	41.3
All Agency	3,348.07	11.44	38,296.94	3.32	7,758.25	2.87	34.8

*Client and taxpayer monetary benefit, resulting from Vocational Rehabilitation over the remaining working life of the rehabilitated person, have been documented to estimate the present value of those future benefits.

Table 5: Minnesota DVR FY 81 Economic Analysis by Administrative Area

Admin. Area	Average Cost Per Rehab.	Client's Income Cost/Benefit Ratio	Average Total Client Benefit*	Taxpayer's Payback Cost/Benefit Ratio	Taxpayer's Net Profit* Per Rehabilitation	No. of Years Required to Repay Cost	Annual Rate of Return (%)
East Metro	$3,519.45	12.05	$42,420.37	3.38	$ 8,372.11	2.62	35.5
West Metro	3,323.22	11.46	38,073.87	3.85	9,458.42	2.48	40.3
Central	3,230.14	13.71	44,269.36	3.44	7,869.23	2.77	36.1
Northwest	3,320.95	10.76	35,732.04	2.61	5,344.23	3.65	27.4
Northeast	3,460.13	11.79	40,794.17	4.06	10,590.92	2.35	42.6
Southwest	3,167.41	10.08	31,925.69	3.05	6,489.28	3.12	32.1
Southeast	3,336.23	9.68	32,289.83	2.35	4,502.65	4.25	24.7
All Agency	3,348.07	11.44	38,296.94	3.32	7,758.25	2.87	34.8

Table 6: Minnesota DVR FY 81 Economic Analysis by Client's Severity of Disability

Severity Dis.	Average Cost Per Rehab.	Client's Income Cost/Benefit Ratio	Average Total Client Benefit*	Taxpayer's Payback Cost/Benefit Ratio	Taxpayer's Net Profit* Per Rehabilitation	No. of Years Required to Repay Cost	Annual Rate of Return (%)
Severity Disabled	$3,579.20	9.26	$33,154.81	2.94	$6,944.70	3.24	30.9
Non-Severely Disabled	3,069.18	14.50	44,501.54	3.85	8,739.88	2.48	40.3
All Agency	3,348.07	11.44	38,296.94	3.32	7,758.25	2.87	34.8

*Client and taxpayer monetary benefit, resulting from Vocational Rehabilitation over the remaining working life of the rehabilitated person, have been documented to estimate the present value of those future benefits.

Table 7: Minnesota DVR FY 81 Economic Analysis by Disability Group

Disability Group	Average Cost Per Rehab.	Client's Income Cost/Benefit Ratio	Average Total Client Benefit[*]	Taxpayer's Payback Cost/benefit Ratio	Taxpayer's Net Profit[*] Per Rehabilitation	No. of Years Required to Repay Cost	Annual Rate of Return (%)
Visual	$2,151.05	15.26	$32,828.32	2.54	$ 3,320.38	3.75	26.7
Hearing	3,855.89	9.20	35,469.92	2.09	4,217.91	3.68	27.2
Orthopedic	3,251.73	13.40	43,585.49	3.67	8,695.32	2.59	38.6
Amputation	3,316.19	10.97	36,381.51	3.77	9,183.08	2.53	39.5
Personality[**] Disorder	2,733.43	14.27	39,004.79	4.99	10,693.14	1.91	52.4
Mentally[**] Retarded	3,913.80	5.48	21,440.19	1.37	1,437.90	6.97	14.3
Neoplasm	3,201.19	15.71	50,279.10	6.06	16,191.15	1.57	63.7
Allergic	4,674.48	10.41	48,673.26	2.13	5,295.51	4.47	22.4
Blood Disease	3,674.42	12.45	45,734.31	3.01	7,377.46	3.17	31.5
Nervous System Disorder	3,596.16	9.21	33,118.70	2.75	6,304.78	3.46	28.9
Cardiac Condition	3,135.96	13.68	42,886.68	4.67	11,505.74	2.04	49.0
Respiratory Disease	3,608.95	13.37	48,236.06	3.20	7,936.19	2.96	33.6
Digestive Disease	3,173.33	10.85	34,441.97	4.43	10,891.52	2.15	46.5
Genito-Urinary Conditions	5,061.85	9.08	45,972.56	1.58	2,934.72	6.03	16.6
Speech Impairment	3,910.20	7.90	30,871.18	2.48	5,784.80	3.84	26.0
Other Disease	3,440.57	10.79	37,138.95	3.12	7,289.92	3.05	32.8
All Agency	3,348.07	11.44	38,296.94	3.32	7,758.25	2.87	34.8

[**] See Tables 8 for expanded data on these Disability Groups.

[*] Client and taxpayer monetary benefit, resulting from Vocational Rehabilitation over the remaining working life of the rehabilitated person, have been documented to estimate the present value of those future benefits.

Table 8: Minnesota DVR FY 81 Economic Analysis by Mental, Psychoneurotic, and Personality Disorders

Type of Disorder	Average Cost Per Rehab.	Client's Income Cost/Benefit Ratio	Average Total Client Benefit*	Taxpayer's Payback Cost/Benefit Ratio	Taxpayer's Net Profit* Per Rehabilitation	No. of Years Required to Repay Cost	Annual Rate of Return (%)
Psychotic Disorder	$2,947.59	9.85	$29,029.53	3.72	$8,005.10	2.56	39.1
Psychoneurotic Disorder	2,973.79	12.16	36,156.18	5.78	14,213.26	1.64	61.0
Other Mental Disorders							
Alcoholism	2,053.89	20.81	42,737.03	6.51	11,310.27	1.46	68.5
Drug Addiction	2,845.99	18.03	51,304.20	5.34	12,346.64	1.78	56.2
Other Behavior Disorders	3,378.00	12.25	41,391.73	3.95	9,952.50	2.41	41.5
Mental Retardation							
Mild Mentally Retarded	3,627.89	7.18	26,037.16	2.07	3,877.22	4.60	21.7
Moderate Mentally Retarded	4,120.94	4.42	18,197.80	.86	(- 562.07)	11.03	9.1
Severe Mentally Retarded	4,665.68	1.94	9,033.52	.11	(-3,160.09)	64.58	1.2

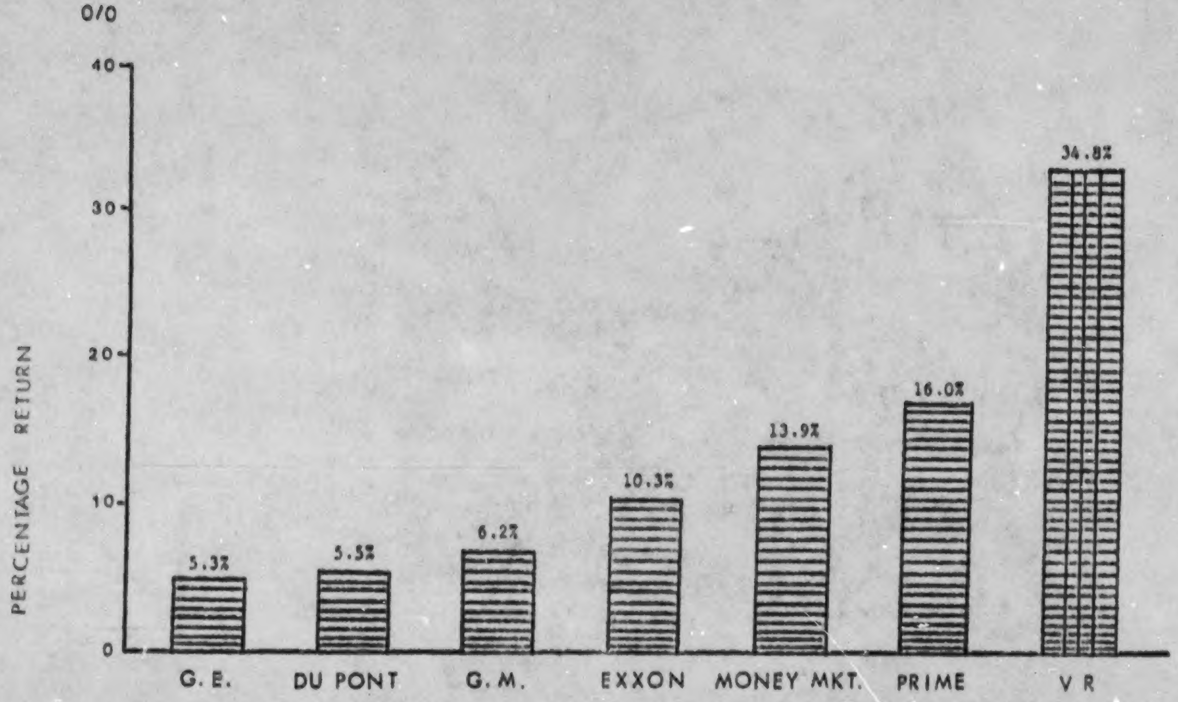
*Client and taxpayer monetary benefit, resulting from Vocational Rehabilitation over the remaining working life of the rehabilitated person, have been documented to estimate the present value of those future benefits.

Table 9: Minnesota DVR FY 81 Economic Analysis by Sex

Sex	Average Cost Per Rehab.	Client's Income Cost/Benefit Ratio	Average Total Client Benefit*	Taxpayer's Payback Cost/Benefit Ratio	Taxpayer's Net Profit* Per Rehabilitation	No. of Years Required to Repay Cost	Annual Rate of Return (%)
Male	$3,268.59	12.95	$42,343.67	3.41	$7,896.15	2.79	35.8
Female	3,474.02	9.18	31,884.50	3.17	7,539.74	3.00	33.3
All Agency	3,348.07	11.44	38,296.94	3.32	7,758.25	2.87	34.8

*Client and taxpayer monetary benefit, resulting from Vocational Rehabilitation over the remaining working life of the rehabilitated person, have been documented to estimate the present value of those future benefits.

CURRENT RATES OF RETURN ON SELECTED INVESTMENTS
as of March 10, 1982



APPENDIX B

The Assessment of Disability In Minnesota

Research and Special Projects Monograph Series
Division of Vocational Rehabilitation
Minnesota Department of Economic Security

THE ASSESSMENT OF DISABILITY IN MINNESOTA

A HOUSEHOLD SURVEY

BY

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This project is unique in several ways. It was a multi-agency effort, financially supported by several State departments. It was also supported by the advice and encouragement of other agencies and it gathered data to meet the information needs of these several agencies.

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Department of Health

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  Governor's Citizens Council on Aging
  State Services for the Blind

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THE ASSESSMENT OF DISABILITY IN MINNESOTA: A HOUSEHOLD SURVEY

INTRODUCTION

Statement of the Problem

There have been many studies which have attempted to estimate the population of the various types of disability groups. Very few of these studies defined disabilities in terms of how they limit the person's ability to function in society. Most of these studies have been based on the medical model which describes the disability in terms of a medical diagnosis or label.

A medical diagnostic model alone gives little information regarding the remaining functional capacities of an individual. It does not include the social, vocational and psychological problems and limitations caused by the disability. For example, a diagnosis of "hemiplegia due to cerebral thrombosis" indicates that the patient has had a vascular lesion resulting in anything from slight weakness to complete paralysis of one side of the body. This medical diagnosis does not define the problems the patient may encounter in living independently, in working, or with functioning in society.

The medical diagnostic model does not provide the information necessary to identify modifications of the work and community environment which will permit the independent functioning of the disabled person. Nor does it indicate what functional capabilities remain

Due to the lack of information on functional limitations and the resulting needs of the disabled, state agencies responsible for providing social, medical and rehabilitative services to the citizens of Minnesota have not had reliable data upon which to plan programs and base decisions concerning the allocation of their resources. The agencies simply do not know the extent and distribution of these kinds of needs among the population and do not know how adequately these needs are being met by current programs.

Objectives of the Study

In order to provide human service agencies in Minnesota with detailed information useful for efficient planning, evaluation and resource allocation, this study attempted to:

1. Estimate the disabled population of Minnesota using a functional definition of disability which included persons having physical disabilities, speech impediments, hearing disabilities, blindness and other visual disabilities, chemical dependency, mental illnesses, and developmental disabilities
2. Provide information on the severity and the nature of disabilities
3. Identify the unmet needs of these disabled persons

This study attempted to provide reliable information to answer the following questions:

1. What proportion of Minnesota's non-institutionalized population is functionally disabled?
2. How can these people be described in terms of age, sex, race, marital status, socio-economic, and educational characteristics?
3. What kinds of functional limitations do they have?
4. Where are the disabled geographically located in Minnesota?
5. To what extent do these disabled persons utilize medical care services and what kinds of problems do they encounter when they seek medical care?
6. What are the major problems reported by disabled persons having different types of disabilities?
7. What services are identified by disabled persons as most needed?

Significance of the Study

In order to make the data more usable, this study adds three dimensions to the experimental design that are not included in other demographic studies of disabled persons:

1. The use of a system of classifying disabilities according to the kind of interference the disability imposes on **functional** areas of living
2. The gathering of disability data in the form of the reporting persons' **perceptions** of existing disabilities within their households
3. The use of a household survey to develop reliable estimates of the disabled population

This study makes a distinction between "impairment" defined by the medical diagnostic model and "functional limitations" and develops an instrument to identify the disabled population in Minnesota according to a functional limitations model. It was hoped that this study would:

1. Identify unmet needs of disabled Minnesotans
2. Provide public and private agencies with data for evaluating the relevance of their services to the current needs of the disabled
3. Be useful in developing and planning more appropriate services to meet the needs identified in this study

Strengths of the Study

This study is unique in its methodology for selecting households to be interviewed and in gathering its data directly from the consumers of human services through extensive interviewing in the home. It focuses on functional limitations which result from disability since it is those functional limitations which interfere with the disabled persons' life styles. It is the perception of disabled persons' functional limitations which results in seeking the resources of human services agencies.

Never before has a systematic survey of these perceived needs been made on a state and regional basis. The different types of information gathered by this study, e.g., general population characteristics, data on the disabled population and needs assessments, etc., can be internally compared because all of the data were obtained from the same sample at the same time. When data are drawn under different circumstances, comparisons are difficult.

The interview method employed by this study produced more accurate information because questions contained in the survey instrument could be clarified until respondents understood what was being asked of them. This method also permitted data-collectors to return to households missed on previous visits which resulted in a return rate on this study of 93 percent.

Limitations of the Study

The design of this study has imposed certain constraints of which the reader should be aware. Disabled persons living in institutions or on military reservations were not included in this study. The time factor may also affect the interpretation of the results. The data were based on household interviews taken in 1976. The extent to which these data will be representative of the year 1978 or later is unknown, although it is felt that differences will be minimal.

Some data inaccuracies are inevitable in an extensive study of this type. Results obtained are subject to three types of errors: (1) sampling errors, (2) errors made in the collection of data, and (3) errors occurring in the process of data compilation.

Data inaccuracies may be caused by interviewers and/or by interview respondents. Interviewers may not have asked the questions the way the questions are worded on the questionnaire. These differences in wording of questions may cause differences in responses and result in data errors. Training sessions designed to minimize this type of error were provided to all survey interviewers. Respondents' unwillingness to answer questions truthfully or their not having accurate information may also have resulted in survey errors.

Data inaccuracies may also result from the fact that approximately seven percent of the occupied households were not interviewed because the respondents were absent, refused to cooperate, or there were no eligible respondents found in the household. Statistical weighting and adjustments were made to limit the effects of these non-interviews.

Another limitation is that the perception of respondents regarding the disabilities reported in the household may be inaccurate. Disabilities identified in this survey were based on responses given by respondents rather than from the disabled individuals' medical records. The extent to which respondents' answers concerning functional limitations corresponded to medically defined conditions is not known.

Studies have shown that information obtained from health interview surveys does not accurately reflect recorded medical diagnoses. However, for use in planning and in identifying areas of perceived needs, household interview surveys are an important tool since the data obtained from this type of survey reflect the respondents' perceived needs and can be used to predict the demand for various social, medical, and rehabilitative services.Since the information in this report represents the perceptions of survey respondents rather than data gathered from official records, readers should expect to find discrepancies between the information reported here and the information possessed by the various human service agencies. It is essential that the users of this report be aware of this when interpreting the data.

Some respondents may have felt reluctant or hesitant to disclose information about their family members which they considered private. As a result, this study's estimate of the disabled population should be considered as a conservative figure since some persons with emotional problems, chemical dependency and other sensitive disabilities may not be identified in this study.

The results presented in this report are based on a univariate descriptive analysis of the data collected. Generalizations or interpretations based on these results may require further statistical analysis of relevant data.

Definition of Terms

Definitions of those terms used in this study which have specific meanings essential to understanding the results follow.

1. Disability is defined, for purposes of this study, as the limitation of capacity or inability to perform the normal activities of living necessary for people to carry out their roles in society. Disabilities result from chronic conditions or impairments. The conditions or impairments included in this study limit a person's performance of expected family, homemaking, work, social, school and/or recreational activities. There are also additional limitations resulting from disabled persons' inability to provide for their own personal care, to physically move about in the home and community, and/or to use their senses to perceive the world about them.

2. Housing Unit means a room or group of rooms, whether occupied or vacant, which are intended for occupancy as separate living quarters. In general, living quarters are considered separate and, therefore, a housing unit exists when (1) the occupants live and eat apart from any other groups in the building, and (2) there is either (a) direct access from the outside through a common hall, or (b) there are complete kitchen facilities for the exclusive use of the occupants, regardless of whether they are used. A housing unit may be occupied by a single family, an extended family, or two or more families living together.

3. Perception, in this study, means the way that interviewed persons understand and describe themselves and others in the interview.

Review of the Literature

The review of relevant literature of the last twenty years has identified four statewide investigations which attempted to estimate the number of disabled Minnesotans.

England, et al, 1958

In 1958, England, of the Industrial Relations Center of the University of Minnesota, conducted a survey of the physically handicapped in Minnesota. Data were obtained from 2,400 household interviews and 523 mail questionnaires completed by hospitals and related institutions. This study defined disability as a physical, emotional, or mental condition or illness which limited an individual's usual activities. This study estimated that 10% of Minnesota's population were disabled. Of this population, 62% were in the labor force range of 14-65 years of age. Of those disabled persons of labor force age, 51% were in need of vocational rehabilitation services. The estimates of the prevalence of disability were based on eleven broad disability categories.

Regional Rehabilitation Research Institute, 1967

In 1967, the Regional Rehabilitation Research Institute of Madison, Wisconsin, conducted a six state telephone survey to identify persons needing vocational rehabilitation services. A total of 1,382 households including 3,428 persons in the age range of 14-70 years were studied; 852 persons reported a disabling physical or mental condition. This survey estimated that 25% of Minnesota's population were disabled. The prevalence rates of each disability group were also reported. Follow-up household interviews were completed with 256 disabled persons to determine their rehabilitation needs. It was found that 20% of the selected 256 disabled persons were both eligible for and interested in receiving rehabilitation services.

Dawis, 1970

Through a grant from the Minnesota Division of Vocational Rehabilitation in 1970, Dawis studied the disabled population in Minnesota. Assuming that the "relative proportions of the constituents of the population had not changed materially in the interim years," he applied the prevalence rates determined by England et. al. in their 1958 study to the 1970 population data for projections. He estimated that 377,000 persons (10% of the state population) were disabled, and that 234,000 (66% of the handicapped population) were in the labor force age range of 14-65 years. Of those 234,000, 119,000 (51% of the handicapped of the labor force age) needed and were eligible for vocational rehabilitation services. Dawis also analyzed annual gains and losses of potential and eligible vocational rehabilitation clients and estimated that 16,000 persons should be added to the target population for vocational rehabilitation services in 1971.

The 1970 Census

In the 1970 Census, disability data were gathered from a five percent sample of the census survey. Respondents were asked if they had a physical disability or condition which limited the kind or amount of work they could do on a job or if their physical condition prevented them from working at all. The results showed that 184,362 individuals or 8.5% of the non-institutionalized population in the age range of 16-64 years were disabled for six months or more.

Inadequacy of Currently Available Estimates

Currently available estimates of the total number of disabled in Minnesota vary from 8.5 to 25% of the population. Estimates of the number in need of rehabilitation services also vary widely. All of these estimates are now out of date. None of the above studies dealt with any functional limitations other than in terms of gross work limitations. None of these studies attempted to provide reliable estimates for specific disability groups or to estimate the geographic distribution of various disabilities throughout the state. Furthermore, the methods used and the information gathered were not appropriate for use in allocating resources and/or for legislative and executive review of public expenditures.

Consequently, agencies responsible for providing social, medical, and/or rehabilitation services have lacked reliable data upon which to determine how to allocate their resources. Further, such agencies do not have the information needed to determine if current programs are adequately meeting the service needs of Minnesota's population. Finally, the number of functionally disabled persons and the nature of their disabilities have never been reliably determined at state or regional levels.

METHODS AND PROCEDURES

This section describes the data gathering methods, procedures for defining the study population and sample selection, the design of the survey instrument, data collection, and the editing, coding, and data processing procedures used in this study. Readers are referred to appendix A for a brief historical and technical description of the methods and procedures used.

Population

The study population consisted of approximately 1,253,000 households and 3,604,782 non-institutionalized persons in Minnesota.

Sample Selection

The Division of Vocational Rehabilitation granted the State Planning Agency funds to undertake the sample selection. The Survey Research Center of the University of Michigan was chosen as sub-contractor to design a stratified multi-stage area probability sample. This sample frame is currently available from the State Demographer's Office for use by other agencies. It was decided that a multi-stage probability sample provided the advantages of flexibility and economy of data collection while assuring the necessary geographic distributions to provide valid data.

A sample of 1,600 housing units was considered to be adequate. The sampling fraction derived was further adjusted to 1 in 500. Thus one housing unit out of each 500 in the state was surveyed. Prior to stratification, 25 of Minnesota's 87 counties were selected to be sampled because they were self-representing and 18 were selected to represent the remaining 62 counties. Further refinement of the sample was done within the county units. This multi-stage sampling procedure was designed to give every housing unit in the state an equal probability of being selected.

Design of the Survey Instrument

Because this study was a cooperative venture of several agencies, their various concerns were considered in developing the survey instrument. All cooperating agencies were asked to list their information needs and areas of concern. The general framework of the instrument was developed from this material and questions were drafted and presented to the agencies for confirmation or correction.

Pretesting was conducted with disabled persons who were rehabilitation professionals or clients, with some randomly selected households and with concerned individuals familiar with the instrument. Three phases of pretesting were conducted and the instrument was revised as necessary and submitted to the coordinating committee for approval.

The organization of the survey instrument consists of the following sections:

1. A "cover sheet" identified the type of family unit and recorded data on age, sex, marital status, education and employment status of family members.
2. "Section A" solicited information about access to medical services, the kinds of services used, hospitalizations, physicians' services, the regularity of physical examinations, distances and time required to reach medical facilities, health insurance coverage, home ownership, occupation, employment status, ethnic background and the combined income of all family members.
3. "Section B" consisted of a series of questions used to identify disabled persons. The questions were selected to cover three categories of major functional limitations in all age groups:
   (1) Major activity limitations: the ability to engage in social activities, attend school, keep house or travel to work
   (2) Chronic mobility limitations: the ability to move about the home and community
   (3) Independent living limitations: significant limitations to self-care caused by difficulty in walking, climbing stairs, stooping, bending or kneeling, handling, grasping or in reaching
4. "Section C" solicited specific information pertaining to disabled persons including their medical status, transportation problems and utilization of public services.
5. "Section D" solicited employment data for employed disabled individuals.

For each person initially identified as disabled, each functional limitation attributed to that person was pursued with a series of questions designed to clarify the nature and severity of the disabled person's problems. The date of onset, origin of the condition, diagnosis of the condition or impairment associated with the functional limitation, and the diagnostician (i.e., physician, speech therapist, respondent, etc.) were determined for each functional limitation.

Also identified was the major problem associated with each disabled individual's diagnosed condition. In-depth questions for persons with hearing impairments, visual impairments, and persons requiring help in personal care were developed at the request of several of the cooperating agencies.

Method of Data Collection

Fifty-six interviewers were selected to carry out the data collection. Many were census interviewers familiar with the areas they surveyed. Three training sessions on interviewing techniques and the use of this specific instrument were conducted. The interviewing began in May, 1976 and ended in September, 1976.

The interview phase was conducted according to generally accepted techniques and standards. Steps were taken to assure the accuracy of data by follow-up calls and/or visits where necessary. A random verification procedure was utilized in which ten percent of the selected households in the metropolitan area and five percent in rural areas were interviewed by telephone for verification of the information provided during initial interviews. None of the interviewers was found to have a pattern of discrepancies.

Editing, Coding, and Data Processing

Completed interviews were checked for correctness and edited for completeness by trained editors. Clarifications, corrections and/or omissions were reviewed weekly and content analyses were done to code responses to open-ended questions.

Responses to medical questions which required review within the context of the respondent's situation were edited by rehabilitation counselors. The Rehabilitation Services Administration's (RSA) classification of disabling conditions was used to code chronic conditions and impairments. Reported disabilities were also classified as severe or non-severe based on the RSA definition of severity. The data packets were then coded for computer analysis.

Sampling Results

The sampling rate adopted was adjusted to one in 500 housing units to yield a larger than necessary sample and more accurate data. This sample fraction resulted in the selection of 2,894 households for interview. In addition to the state sample, a sufficient number of households was selected for interview to permit regional analyses for the Metropolitan, St. Cloud and North Central regions.

Of the 2,894 households selected, 2,516 or 87% were considered valid. The remaining 13% were invalid because of (1) seasonal residence, (2) vacant household, (3) address not a dwelling and (4) errors made by listers.

Completed interviews were obtained from 2,335 households, or 93% of the valid households. Seven percent (181) of the households could not be interviewed. Of the non-interview households, 131 refused to be interviewed, 39 did not have anyone at home when interviewer called, 9 did not have appropriate respondents at home and 2 did not have eligible respondents.

Population Estimation and Sampling Error

The study was designed to produce reliable statewide estimates of the populations of various disability groups. Since these estimates were derived from a sample, they were subject to sampling and field work errors.

Standard errors used to measure sampling variability were computed using a paired comparison method for "self-representing primary units" and a successive difference model for "non-self-representing primary units." Standard error computations were made on those variables which were projected to the state population such as socio-economic and demographic characteristics, and services needed.

The sampling procedure was designed to provide each housing unit in Minnesota with an equal probability of selection. Thus, no weighting for each housing unit was required. However, since there were some housing units for which no interviews could be obtained, it was necessary that weights for all interviewed units be adjusted when estimating the total population. The adjustment was made for each chunk according to the following formula which computes weight for population estimates on the valid housing units of the sample.

$$\text{Weight} = \frac{\text{number of housing units selected}}{\text{number of housing units interviewed}} \times 500$$

On the results of this sampling, the statewide non-institutionalized population was estimated at 3,604,782. The standard error for the population estimate was approximately 2.4 percent.

Presentation of the Data

Three types of information were gathered from this survey: (1) data pertaining to the families, (2) data pertaining to the individual family members, and (3) data pertaining to the disabled. Both sample statistics and estimates of statewide populations were run for each type of data. Information presented in this report is primarily data pertaining to the disabled. Percentages reported in this document are based on the statewide estimates developed from the sample statistics obtained in this study. Sums of the percentages are rounded to the nearest decimal and may not always equal 100 percent.

RESULTS

The primary objective of this study was to develop reliable estimates of the number of persons in Minnesota perceived by family members as disabled, using a definition of disability based on functional limitations. This study also attempted to provide detailed information on the severity and nature of the disabilities as well as to identify the unmet needs of the disabled.

Data relating to these objectives are presented in the following sections. Most of the percentages used in this report are based on the statewide estimates of the disabled. The estimated numbers of functionally disabled persons reported in this study resulted from applying the prevalence rates derived from the study to population estimates furnished by the State Demographer's Office of the State Planning Agency.

Total Disabled Population Identified

Approximately one in seven (14.5%) non-institutionalized Minnesotans was identified as having a functional disability. The metropolitan area of the state was found to have a higher disability rate than the rural areas. The metropolitan area (including Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties) had a functional disability rate of 16.5% while the rest of the counties in the state had a 12.7% rate of disability. Table I shows the estimated prevalence rates of functional disabled Minnesotans.

Almost 99% of these disabled persons lived in primary family units. Approximately three families in ten had one or more functionally disabled members.

The Distribution of Disabled Persons by Region

Regional populations of the functionally disabled were estimated by using the prevalence rates derived from this study. A majority of functionally disabled persons (55.2%) lived in Region 11, the seven counties of the metropolitan area. Region 10 (Olmsted, Winona and Wabasha counties) contained 9%. An additional 8% were identified in Region 3 (St. Louis, Lake and Cook counties). Other regions each had less than 5%. Further information is reported in Table II.

The Distribution of Disabled Persons by County

If the urban rate is applied to populations of urban counties and the rural rate to appropriate counties, an estimate of the number of functionally disabled persons can be made for each county. Table III shows these estimates.

Socio-Demographic Characteristics

1. Relationship to Head of Household

   Nearly half (47%) of the disabled persons identified were the head of the household. Approximately one fifth (22%) were spouses and approximately one quarter were children. An additional 3% were relatives or in-laws and 1% were not related to the head of the household.

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2. Age

Disabled persons identified in this study tended to be older than the general population. The average age of the disabled persons identified in this study was 45.5 years. The average age of the general population was about 32 years. The youngest disabled person identified was less than one year old and the oldest was 96.

Approximately one quarter (24%) of the disabled group were 19 or younger. Those of working age, between 20 and 64 years, made up nearly half the population (45%). Roughly a third (30%) of the disabled persons were 65 and older and 15% of the disabled persons were 75 and older.

3. Sex and Marital Status

The functionally disabled persons identified in this study were equally divided between male and female. Nearly 49% of disabled persons were married, a third (33%) had never married and the remaining 18% were widowed, divorced or separated.

4. Educational Level

Slightly over three-fourths (76%) of the disabled were not enrolled in school at the time of the interview. Of those who were in school, 85% were full-time students and 15% were part-time students. The average educational level of disabled persons was 9.3 years. Nearly 5% had never attended school; 14% did not go beyond grade school; 30% had a junior high school education; 33% had a high school education; 15% had some college or university and just under 2% had post-graduate education.

5. Employment Status and Income

Two-thirds of the functionally disabled persons identified were unemployed at the time of the interview. Of those persons who were working, 58% worked between 31 and 40 hours per week. Another 24% worked over 40 hours. Part-time workers (those who worked less than 30 hours per week) accounted for 17% of the working disabled population with 3% working less than 10 hours a week. The hours worked by disabled persons in this study ranged from 4 to 80 hours per week with an average of 39.4 hours. Of those who were currently working, 7% had more than one job.

Employed functionally disabled persons had an average annual income of $9,402 before deductions. In addition to income from current employment, one-quarter (25%) had income from other sources. Of these, three out of four (75%) received benefits from other sources including: Social Security, Veteran's Disability Benefits, Unemployment Compensation, Worker's Compensation, private or public insurance, pension or retirement funds, welfare, food stamps, rental units, sales profits, investments, or interest.

Slightly over three-fourths (76%) of the functionally disabled persons currently working worked in the competitive labor market; 18% were self-employed; and 7% worked in a sheltered workshop. Most expressed satisfaction with their current job; 36% were very satisfied; 48% were satisfied; and 8% were dissatisfied.

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Of the functionally disabled persons not currently working, 42% were retired; an additional 26% were housewives not employed outside the home; 7% were students; 17% were not working because they were too disabled; 5% were currently unemployed; 1% were laid off; and 2% were on sick leave. Of those not currently employed, 6% reportedly had looked for work in the past four weeks prior to the interview.

Of those disabled who were not working at the time of the interview, nearly 85% had worked for pay before and over 16% were available for work. Of those who were available for work, 45% were interested in referral for assistance in finding a job.

Functional Limitations of the Disabled

This study identified the disabled in terms of the physical, mental or sensory limitations that interferred with or limited their ability to carry out the normal activities of life such as working, keeping house, attending school or engaging in social activities available in the community. Table IV describes these limitations and indicates their prevalence in Minnesota.

A survey of Table IV depicts the types of problems encountered by the disabled and the number of persons having specific functional limitations in Minnesota's population. It is more revealing and meaningful to know that 86,000 people have trouble going up or down stairs, 75,000 have trouble in walking over uneven ground, and 35,000 are unable to use public or private transportation than it is to know that 312,000 persons have physical disabilities (Table VI). A perusal of these functional limitations will quickly begin to suggest areas of concern for future architectural design, human services and social and vocational planning.

Table V describes those limitations more specifically related to pre-school and school age disabled. It reflects some of the concerns that should be addressed in planning efforts to serve this population's current needs and to develop the skills they will need to perform their adult roles in society.

Description of Disabled Persons by Major Disability Category

According to the medical model for describing these disabilities, 60% were physically disabled; 13% had hearing disabilities; 5% had visual disabilities; 3% were classified as having developmental disabilities (mental retardation, cerebral palsy, epilepsy, dyslexia, and autism); over 2% were identified as having a mental illness; over 1% had speech impairments; and 1% had an addictive disorders. Almost 15% of the population identified as disabled could not be classified as to the type of disability because of insufficient information. Table VI shows the estimated number and percentage of each of the major disability categories.

Distribution of Disabled Persons According to the Severity of Disability

Of the 321,544 persons estimated as functionally disabled in this study, approximately 276,000 were of working age (between 16 and 65). Slightly over 25% or 71,000 of these persons of working age were estimated to be severely disabled and 62% or 179,000 were not severely disabled. An additional 13% or 35,000 were persons for whom the severity of disability was undeterminable from the data provided (See Table VII).

Aids Used by Disabled Persons

Approximately 11% of the functionally disabled persons used physical aids to increase their independence in everyday life. Of these, approximately 40% used a cane, 22% used braces or special shoes, 8% used crutches or walkers, 4% used wheelchairs and 2% wore artificial limbs. Almost one in seven (13%) of disabled persons using an aid used two types of aids and nearly 4% used three or more.

Problems Associated with Disability

Nearly two-thirds (65%) of the respondents indicated that the most serious problems associated with disabling conditions involved the disabled persons' making physical adjustments for the limitations imposed by the disability such as the inability to care for themselves; loss of sight, hearing, touch; diet restrictions; immobility; etc.

Employment problems due to physical or behavioral limitations were cited by 12% as most important. Problems with social and interpersonal relationships were reported by 9% as most important. Educational problems involving difficulty in learning, comprehension or behavior were perceived as the most important for 8% of the disabled and mental problems and adjustments in coping with the disability were cited as the most important problem by 6% of the respondents.

Transportation Available to Disabled Persons

Respondents generally indicated that disabled persons had private transportation available to them in their community. Eighty-six percent had cars driven by friends or relatives available to them. Fifty-three percent could drive their own automobiles and 54% had taxis available in their community. Over half (57%) had public bus service available in their communities. Most indicated that private bus service, volunteer transportation systems, and medical vans were not available within their community.

Services Received and Needed by Disabled Persons

Persons interviewed in this research were given a list of sixteen broad descriptions of services provided by public agencies ranging from planning for a job or career, speech therapy, or home health care to public or subsidized housing. Respondents said that almost 30% of the disabled had received one or more of these services and 14% indicated they were receiving such services at the time of the interview.

Most of the service recipients had received one service but some had received more than one. Seventeen percent said they needed one or more services that they had not received previously. Of these, half (54%) indicated that they needed one service, 24% needed two services and 12% needed more than two services. Table VIII presents statewide estimates of public services received and needed by disabled persons.

Who Should Provide Services to the Disabled

Because disabled persons may require a variety of services from many sources, families were asked to express opinions about who should provide such services.

The preferred provider for medical care services was the federal government. Nearly half (47%) of the respondents stated their preference for federal support, 39% preferred state government support and an additional 20% favored county government support for medical care services. State government was the preferred service provider for job training services by 52% of the disabled persons; an additional 25% preferred the federal government as the provider of such training services. County and local governments were preferred for job training services by 19% of the respondents.

The federal and state governments were equally favored for providing income support. For assistance with employment counseling and job placement, 38% preferred local government and 27% preferred county government.

Local government was seen by 34% of the interviewed families as the most appropriate provider of special housing arrangements. State and county governments were favored for such services by 30% and 27% respectively. For the provision of special transportation services, 42% preferred local government, 24% county government, 22% voluntary agencies; 19% state government, and 8% federal government. Table IX displays the respondents' perceptions of who should provide the various types of services needed.

In summary, the federal government was preferred as the service provider for medical care and income support; state government was favored for job training, income support, and employment counseling; and local government for special housing arrangements and special transportation services. A majority (53%) of the families interviewed felt that state government should increase its funding support for services to disabled persons. Nearly 84% of the families interviewed considered this kind of survey of health and disability a proper function of state government.

The Use of Medical Care

1. Problems in Receiving Medical Care

Generally, disabled persons encountered more problems in obtaining medical care than the general population. The problem most often mentioned for disabled persons was the cost of medical care. In addition, disabled persons had difficulty in getting medical care because the doctors' office hours were inconvenient or their offices were closed when the services were needed. A significant number of the disabled had difficulty in obtaining medical care and many more were prevented from obtaining medical care due to the above reasons.

Other problems encountered in receiving medical care include: not being able to get a physician because of lack of transportation, no doctor was available when required, or not knowing where to go for medical services.

2. Overnight Hospitalization

A considerably higher proportion of disabled persons had been hospitalized (24%) than of the general population (11%) surveyed. Disabled persons also had longer hospital stays than the general population with nearly 60% of them having stays exceeding five days.

Disabled persons who were hospitalized generally went to the hospital in privately owned vehicles and traveled in excess on one-half hour to get to the hospital. About two-thirds (66%) of the disabled were referred for hospitalization by a physician.

The most frequent conditions requiring hospitalization were diseases of the circulatory system and of the digestive system. However, a wide variety of medical conditions was represented in the reasons given for hospitalization. Surgery was also cited frequently as a reason for hospitalization.

Slightly less than one-third of the disabled had insurance to help pay the costs of their hospitalization. For those who did not have insurance, the average cost of hospitalization was $230.

3. Doctors Appointments

Disabled persons also saw their physicians more frequently than the general population, 59% as compared with 42% of the general population. Most of them (86%) used privately owned vehicles to go to the physician's office and it took them less than half an hour (22 minutes) on the average to get there. Most frequently, the physician they saw was the family doctor, although they reported seeing other physicians for a variety of reasons. The cost of doctors' visits for disabled persons averaged slightly over $40.

4. Physical Examinations by Physician

Nearly half (46%) of the disabled persons were reported as having had a check-up or physical examination within the last two years. Typically, these examinations included standard laboratory tests and X-Ray procedures appropriate to their individual needs. The survey showed that 46% of the disabled had medical check-ups during the 2 year period prior to the survey while 41% of the general population had such check-ups.

5. Health Insurance

The results of this survey indicate that slightly over 90% of Minnesota families had at least one family member covered by health insurance. Of those families covered by insurance, approximately three quarters (74%) had policies with commercial insurance companies and an additional 12% were covered by Medicare. Nearly half (48%) of the families with health insurance had coverage for all or most of their family members. Less than half (45%) of the families had employer or union participation in payment of their insurance premiums.

Approximately 10% of the families did not have health insurance of any kind. The main reason given for not having health insurance was that it was too expensive (46%); they received Medicare or welfare coverage of medical costs (16%); they did not need health insurance (10%); and they could not obtain health insurance because of age, illness or poor health (6%).

SUMMARY AND CONCLUSIONS

State agencies responsible for providing social, medical, and rehabilitative services to the citizens of Minnesota have not had reliable data upon which to base decisions concerning the allocation of their resources. Currently available data are out of date or were obtained from studies which have not defined disability in terms of how the disabling condition limited their ability to function in society.

In order to provide reliable estimates of the perceived disabled population in Minnesota for use by human service agencies, this study attempted to:

1. Estimate various disabled populations in Minnesota using a functional definition of disability
2. Provide information on the severity and nature of the disabilities
3. Identify the unmet needs of the disabled identified in this study

The data for this study were collected from a sample of households throughout the state. An extensive interview was conducted in each of these households to determine the number of functionally disabled persons living there and their needs. This sample consisted of 2,335 households and yielded interview data on 6,730 Minnesotans including 964 persons identified as functionally disabled.

Sampling

The Division of Vocational Rehabilitation made a grant to the State Planning Agency to develop a statewide sample frame from which to draw housing units for interview. The Survey Research Center of the University of Michigan developed this sample frame and provided the methodology for assuring the technical quality of the sample. Two sets of sample frames were developed for this study and are available from the State Planning Agency for use in other surveys.

The statewide sampling rate was one housing unit in each 500. This resulted in the selection of 2,894 households for the state sample. Usable completed questionnaires were obtained from 2,335 of these households.

Instrument and Data Collection

The survey form was developed from an analysis of the cooperating agencies' requests for data. The form went through several revisions as a result of continuous input from these agencies. Detailed questions were asked of each family member identified as having a limitation in ordinary functions appropriate to that person's life style. The questionnaire was pretested three times and revised when necessary.

The survey was conducted during the summer and fall of 1976 by trained interviewers including a large proportion of experienced census interviewers. By analyzing the data obtained from the survey, the main objectives of this study were achieved.

Characteristics of the Disabled Population

Approximately one in seven (14.5%) non-institutionalized Minnesotans was found to have functional disabilities. Physical disabilities accounted for most of the functional limitations. Disabilities such as speech, hearing, blindness and other visual impairments, mental illness, chemical dependency, developmental disabilities etc., accounted for much smaller proportions.

Adjustments to physical limitations and employment related difficulties were perceived as the most important problems associated with disabling conditions. The disabling conditions were rated as severe or non-severe according to the Rehabilitation Services Administration Classification System. Of those disabled persons between the ages of 16 and 65, 26% were identified as being severely disabled.

The sexes were equally represented among disabled persons. Nearly half (49%) of the disabled were married. About a fifth (20%) were less than 16 years of age and 30% were 65 or older. The disabled had an average of 9.3 years of education with about one-third completing their high school education. More than half lived in the metropolitan area with Hennepin County having the largest number of disabled persons.

A third (33%) of the disabled persons 16 years or older were working at the time of the interview. Slightly over three quarters (76%) of those currently working were employed in the competitive labor market, 18% were self-employed, and about 7% worked in sheltered workshops. The employed disabled worked from 4 to 80 hours per week with an average of 39.4 hours.

The average annual income for disabled workers was $9,402 before deductions. About 25% of the employed disabled also received financial assistance from sources other than their jobs.

Transportation Available

Most of the disabled persons identified had privately owned vehicles driven by friends or relatives available to them in their communities. Many disabled persons (53%) could drive their own vehicles. Public bus service was available to over half (57%) of the disabled persons. Less than 17% had private bus or voluntary transportation systems or medical van services available to them in their communities.

Services Needed

About one in three (30%) of the disabled had received one or more public services from human service agencies. Almost 19% were currently receiving public services at the time of the interview. Over 17% indicated a need for at least one public service. The type of public services needed varied widely. No more than 10% of the disabled population needed any one type of service.

When asked who should provide services to disabled persons, Minnesota families in general preferred the federal government as the service provider for medical care and income support; state government for job training, income support and employment counseling; and local government for special housing arrangements and special transportation services. A majority of those surveyed felt that state government should increase its funding for services to disabled persons.

Use of Medical Care

Disabled persons were found to have a higher hospitalization rate, a higher frequency of contact with physicians, and a higher porportion with problems in obtaining medical care than was true for the general population. Cost was the most frequently cited problem in obtaining medical care for disabled persons. This cost factor delayed 44% and prevented 31% of those citing this problem from obtaining medical care.

Slightly over 90% of the families had at least one member covered by a health insurance policy. Of those families with health insurance coverage, 48% had coverage for all or most of their family members. Of the 10% who carried no health insurance the most frequently stated reason was that it was too expensive.

Conclusion

The major accomplishments of this study are:

1. The provision of reliable estimates of the perceived prevalence of disability among the non-institutionalized population of Minnesota
2. The identification of various types of functional limitations in this disabled population
3. The identification of many unmet needs that disabled persons have

The data obtained in this study will provide a base of information about functionally disabled Minnesotans. Planners, policy managers and service providers of various public and private agencies at all levels may use this information to assist them in developing their programs, and legislators may find this information useful in allocating state resources. This data base provides state agencies with information never before available to any state government for use in identifying the needs of its citizens.

The major finding of this study was that the best estimated prevalence rate of functionally disabled persons in Minnesota is approximately 521,544 or 14.5% of the estimated non-institutionalized population of the state. In many instances data are summarized as percentages of the total estimated number of disabled persons and because the percentages are small, they may appear to be insignificant. However, this is not the case. For example, the reported figure of 5.9% of disabled persons needing training for employment represents 30,913 disabled persons who are in need of job training.

This study has established a data base that is available for answering specific questions that agencies or interested groups may have. The full value of the study can only be realized when agencies use this data base to address their particular planning needs. Access to the data files is possible through contact with the Management Support Unit of the Division of Vocational Rehabilitation, 444 Lafayette Road, St. Paul, Minnesota 55101.

APPENDIX A

HOW THE RESEARCH WAS ACCOMPLISHED

Sampling Strategy:

The Division of Vocational Rehabilitation contracted with the State Planning Agency for assistance in developing the study sample frame. The State Planning Agency contracted with the Survey Research Center of the University of Michigan to design a stratified multistage area probability sampling model for Minnesota. The sampling procedure was then applied to demographic data needed to select the study sample frame.

The two major characteristics of the design which became parameters for the sample were the known probability of sample selection and the economy of data collection. The sampling design which the Survey Research Center developed required that counties be grouped according to their similarity on known demographic data. After the representative counties were chosen from within each group, individual housing units were selected.

Survey Instrument Design

All of the cooperating agencies sent their questions to the coordinating committee for inclusion in the survey instrument. The instrument was field-tested three times and went through many revisions for integration and refinement. The first field test was carried out by experienced census interviewers on persons who were known to be disabled, both professional persons (mostly DVR counselors) and persons known to DVR as clients.

In the second test, the instrument was applied to a sample which included persons known to be disabled and others known not to be disabled. This test was run to assure that the instrument would, in fact, discriminate between the two groups.

The third test was conducted on a randomly selected street, which approximated a section of the study but was not included in the study sample. These trials were run using professional survey interviewers and research consultants involved in the study. The field testing clarified some of the details but revealed no significant flaws in the survey instrument.

Data Collection

The data collection phase was then implemented. Interviewers were selected, employed and trained. Most out-state interviewers were experienced census takers familiar with the areas in which they worked for this project. All interviewers went through structured training sessions on the survey instrument and on general interviewing techniques.

Procedures were developed to audit all completed survey forms. Returned questionnaires were edited for completeness by trained editors and items were checked for consistency with the data on each form.

The data were then coded for computer analysis and the coding was then audited for accuracy. Data based on the univariate analysis of each question included in the survey instrument are available to all interested agencies and form the basis for this report.

APPENDIX B

Table I

Estimated Prevalence Rates of Functionally Disabled Persons in Minnesota

Area	Prevalence Rate
Total State	14.5%
Metropolitan Area-consisting of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties	16.5%
Non-Metropolitan Area-consisting of all other counties	12.7%

Table II

Estimated Prevalence of Functionally Disabled Persons in Minnesota By Region

Region	Regional Population[1]	Estimated Prevalence Rate (%)	Number of Disabled Number[2]	(%)
Region 1	98,100	12.7	12,459	2.1
Region 2	60,900	12.7	7,735	1.3
Region 3	337,500	12.7	42,863	7.5
Region 4	193,700	12.7	24,599	4.3
Region 5	124,100	12.7	15,761	2.7
Region 6E	103,000	12.7	13,081	2.3
Region 6W	62,100	12.7	7,887	1.4
Region 7E	90,600	12.7	11,507	2.0
Region 7W	202,200	12.7	25,680	4.5
Region 8	140,700	12.7	17,869	3.1
Region 9	218,600	12.7	27,763	4.8
Region 10	398,900	12.7	50,661	8.8
Region 11	1,924,100	13.5	317,477	55.2
All Minnesota	3,954,500	14.5	575,342[2]	100.0

[1] Regional populations are based on estimates made on July 1, 1976, see "Population Estimates for Minnesota Counties 1977," published by Office of State Demographer, State Planning Agency, July, 1978.

[2] These figures represent the estimated numbers of disabled based on the total state population.

Table III

Estimated Numbers and Percentages of Functionally Disabled Persons by County

County	County Population[1]	Estimated Prevalence[1] Rate of Disabled (%)	Estimated Number of Disabled
Aitkin	12,700	12.7	1,613
Anoka	189,900	16.5	31,334
Becker	27,300	12.7	3,468
Beltrami	29,800	12.7	3,785
Benton	22,400	12.7	2,845
Big Stone	7,800	12.7	991
Blue Earth	51,400	12.7	6,528
Brown	29,400	12.7	3,734
Carlton	29,000	12.7	3,683
Carver	33,900	16.5	5,594
Cass	20,000	12.7	2,540
Chippewa	15,700	12.7	1,994
Chisago	22,300	12.7	2,833
Clay	47,300	12.7	6,008
Clearwater	8,800	12.7	1,118
Cook	4,100	12.7	521
Cottonwood	15,100	12.7	1,918
Crow Wing	38,800	12.7	4,928
Dakota	178,900	16.5	29,519
Dodge	13,500	12.7	1,715
Douglas	25,100	12.7	3,188
Faribault	20,100	12.7	2,553
Fillmore	22,000	12.7	2,794
Freeborn	36,900	12.7	4,686
Goodhue	38,200	12.7	4,852
Grant	7,600	12.7	966
Hennepin	916,000	16.5	151,140
Houston	18,100	12.7	2,299
Hubbard	12,500	12.7	1,588
Isanti	20,000	12.7	2,540
Itasca	40,100	12.7	5,093
Jackson	14,500	12.7	1,842
Kanabec	11,400	12.7	1,448
Kandiyohi	33,000	12.7	4,199
Kittson	6,900	12.7	877

(continued)

Table III (Cont'd)

Estimated Numbers and Percentages of Functionally Disabled Persons by County

County	County Population[1]	Estimated Prevalence[1] Rate of Disabled (%)	Estimated Number of Disabled
Koochiching	17,500	12.7	2,223
Lac Qui Parle	11,100	12.7	1,410
Lake	13,700	12.7	1,740
Lake of the Woods	4,100	12.7	521
Le Sueur	21,600	12.7	2,744
Lincoln	8,400	12.7	1,067
Lyon	24,600	12.7	3,125
McLeod	28,800	12.7	3,658
Mahnomen	5,700	12.7	724
Marshall	13,300	12.7	1,690
Martin	24,800	12.7	3,150
Meeker	20,200	12.7	2,566
Mille Lacs	18,000	12.7	2,286
Morrison	28,000	12.7	3,556
Mower	43,200	12.7	5,487
Murray	12,100	12.7	1,537
Nicollet	25,100	12.7	3,188
Nobles	23,100	12.7	2,934
Norman	5,600	12.7	1,220
Olmsted	89,700	12.7	11,392
Otter Tail	48,800	12.7	6,198
Pennington	14,900	12.7	1,893
Pine	18,900	12.7	2,401
Pipestone	11,800	12.7	1,499
Polk	35,700	12.7	4,534
Pope	11,300	12.7	1,436
Ramsey	457,700	16.5	75,521
Red Lake	5,300	12.7	674
Redwood	19,500	12.7	2,477
Renville	21,100	12.7	2,680
Rice	44,000	12.7	5,588
Rock	11,000	12.7	1,448
Roseau	12,400	12.7	1,575
St. Louis	220,400	12.7	27,991
Scott	40,700	16.5	6,716
Sherburne	26,900	12.7	3,417
Sibley	15,700	12.7	1,994
Stearns	104,000	12.7	13,208
Steele	28,900	12.7	3,671
Stevens	11,300	12.7	1,436

(continued)

Table III (cont'd)

Estimated Numbers and Percentages of Functionally Disabled Persons by County

County	County Population[1]	Estimated Prevalence[2] Rate of Disabled (%)	Estimated Number of Disabled
Swift	13,300	12.7	1,690
Todd	23,700	12.7	3,010
Traverse	6,100	12.7	775
Wabasha	18,700	12.7	2,375
Wadena	13,600	12.7	1,728
Waseca	18,000	12.7	2,286
Washington	107,000	16.5	17,655
Watonwan	12,500	12.7	1,588
Wilkin	8,900	12.7	1,131
Winona	45,700	12.7	5,804
Wright	48,900	12.7	6,211
Yellow Medicine	14,200	12.7	1,804

[1] County populations are based on estimates made on July 1, 1976, see "Population Estimates for Minnesota Counties 1977," published by The Office of State Demographer, State Planning Agency in July, 1978.

[2] Two prevalence rates are used: (1) The estimated prevalence rate for the metropolitan area which is 16.5 percent, and (2) the estimated prevalence rate for the non-metropolitan area which is 12.7 percent. (See Table I.)

Table IV

Statewide Estimates of Perceived Functional Limitations[1] — All Ages

Type of Functional Limitation	Number	Percent[2]
Limited in the amount or kind of work because of having to take rest periods, not doing strenuous work, etc.	142,765	27.4
Have trouble in stooping, bending or kneeling	114,830	22.1
Have trouble in lifting or carrying	96,238	18.5
Unable to work at outside job	94,989	18.2
Have serious hearing loss	93,096	17.9
Have trouble in going up or down stairs	86,051	16.6
Have difficulties doing a job for pay because of limited physical abilities	80,815	15.5
Limited in outside activities such as church, clubs etc., because of physical or emotional health reasons	76,437	14.7
Have trouble in walking over uneven ground	74,787	14.4
Have trouble in reaching with one or both arms straight over head	66,003	12.7
Need special medicine to control severe breathing difficulties	42,721	8.2
Have trouble reading print even when wearing glasses	41,210	7.9
Need special medicine to control diabetes	40,831	7.8
Cannot see clearly even when wearing glasses	39,742	7.6

(continued)

Table IV (Cont'd)

Statewide Estimate of Perceived Functional Limitations[1] — All Ages

Type of Functional Limitation	Number	Percent[2]
Unable to use private or public transportation	35,261	6.8
Have fainting spells, blackouts, etc.	32,339	6.2
Need special medicine to prevent or control fainting spells, seizures, etc.	29,642	5.7
Have problems speaking clearly	28,617	5.5
Have trouble in picking up small objects between thumb and first finger	24,781	4.8
Need special medicine to control muscle spasms or shaking	21,875	4.2
Have difficulties getting along with others	19,895	3.8
Unable to leave the house because of permanent disability	12,392	2.4
Need assistance in looking after personal needs	10,310	2.0
Restricted in work because of seizures	8,392	1.6
Have trouble holding job because of emotional problems	8,280	1.6
Have trouble holding job because of drinking or drug problem	7,641	1.5
Restricted in work because of need for close supervision	5,125	1.0
Have two or more arrests	2,700	.5

[1] Functional limitations are not mutually exclusive. One person may have two or more functional limitations.

[2] Percentages are based on the total estimated number of disabled persons. Since the disabled may have several limitations, the percentages do not add up to 100%.

Table V

Statewide Estimates of Perceived Functional Limitations Specifically Related to Children

Type of Functional Limitation[1]	Number	Percent[2]
1. Pre-school children (through 4 years of age)		
Slow in learning to eat, dress or develop toilet habits	5,475	1.0
Slow in learning to talk or walk	3,500	0.7
Withdrawn when approached by others	3,125	0.6
Unable to play the way normal children do	2,250	0.4
Unable to play because of injury	1,500	0.3
2. School-age Children (5 to 18 years of age)		
Need special assistance in reading, writing or spelling	55,345	10.6
Have to go to special school	27,752	5.3
Have memory lapse, daydreams	22,350	4.3
Have behavior or discipline problems	14,919	2.9
Unable to take part in active games	14,869	2.9
Withdrawn when approached by others	6,625	1.3
Unable to go to school because of injury	1,000	0.2

[1] Functional limitations are not mutually exclusive. One person may have two or more functional limitations.

[2] Percentages are based on the total estimated number of disabled persons and will not add up to 100%

Table VI

Statewide Estimated Number and Percentage of Disabled Based on the Medical Model of Disability

Major Disability Category	Number	Percent
Physical disability	311,915	59.8
Speech	7,146	1.4
Hearing	65,621	12.6
Blindness and vision	26,412	5.1
Chemical dependency (addictive disorders)	5,891	1.1
Mental illness	12,515	2.4
Developmental disabilities	16,247	3.1
Not ascertainable	75,796	14.5
TOTAL	521,544[1]	100.0

[1] This figure represents the estimated number of non-institutionalized functionally disabled identified in this study and is different from the total number of disabled estimated on the basis of the total state population as as shown in Table II.

Table VII

Estimated Number and Percentage of Disabled Persons by Severity[1] of Disability

Severity of Disability	Number	Percent
Severely Disabled	70,618	25.6
Non-severely Disabled	169,954	61.6
Undeterminable Severity	35,216	12,8
TOTAL	275,788[2]	100.0

[1] Rehabilitation Services Administration definition of severe disability was used for classification.

[2] Total excludes 245,756 disabled under 18 or over 65 years of age.

Table VIII

Statewide Estimates[1] of Public Services Received and Needed by Disabled Persons

Type of Service	Services Received During Past Twelve Months		Unmet Service Needs[2]		Total Perceived Needs	
	Number	Percent	Number	Percent	Number	Percent
Vocational Services:						
Career or Job Planning	19,263	3.7	26,899	5.2	46,162	8.9
Job Training	13,305	2.6	30,913	5.9	44,218	8.5
Sheltered/Supervised Employment	3,625	0.7	5,625	1.1	9,250	1.8
Job Finding Assistance	15,410	3.0	29,096	5.6	44,506	8.6
Personal Services:						
Personal or Family Problem Counseling	33,873	6.5	30,752	5.9	64,625	12.4
Home Health Care	15,851	3.0	15,060	2.9	30,911	5.9
Home Delivered Meals	3,833	0.7	6,458	1.2	10,291	1.9
Housekeeping & Home Maintenance	15,876	3.0	24,693	4.7	40,569	7.7
Therapy:						
Physical or Occupational Therapy	25,348	4.9	21,178	4.1	46,526	9.0
Speech Therapy	14,227	2.7	14,752	2.8	28,979	5.5
Hearing Therapy	2,250	0.4	30,158	3.1	32,408	3.5
Educational Services:						
Special Education Programs	49,387	9.5	41,251	7.9	90,638	17.4
Day Activity/Day Care Programs (out of home	2,200	0.4	6,000	1.2	8,200	1.64
Special Living Arrangements:						
Full Time Living Arrangements Outside The Home	2,000	0.4	2,750	0.5	4,750	0.9
Public Housing/Subsidized Housing	5,975	1.1	12,558	2.4	18,533	3.5
Organized Recreational Services	24,058	4.6	26,006	5.0	50,064	9.6

[1] Estimated numbers and percentages are based on the total statewide estimated population of disabled persons. These estimates do not necessarily correspond with the records of public agencies since these data are based on the **perceptions** of survey respondents.

[2] These figures represent persons who had not received the indicated services in the past 12 months but perceived the need for them.

Table IX

Perceptions of Who Should Provide Services to Disabled Persons[1]

Type of Service	Alternative Providers					
	Federal Gov't	State Gov't	County Gov't	Local Gov't	Voluntary Agencies	No Opinion
Medical Care	47.4	39.0	20.5	13.8	3.3	9.4
Job Training	25.4	51.8	19.1	19.7	8.2	8.7
Income Support	44.0	43.2	18.4	9.0	3.3	10.3
Employment Counseling	9.1	37.4	26.7	30.5	11.5	9.2
Special Housing Arrangements	18.4	29.8	27.1	34.7	7.6	9.9
Special Transportation Services	8.0	19.7	23.7	42.1	22.0	9.8

[1] Multiple responses were given. The percentages were based on the total number of families from which a complete interview was obtained.

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Mr. **Erdahl**. I think at this time it would be appropriate to have a brief interruption of the panel to welcome our chairman, the chairman of the Select Education Subcommittee, Mr. Austin Murphy from Pennsylvania. I think it is a sign of his dedication and concern in this whole area of the handicapped and rehabilitation and a proper attitude of the country and the Congress toward them the fact that he has interrupted his recess from Congress and his campaign to join us in St. Paul, Minn. I am very happy to welcome my chairman to Minnesota and to introduce him to you who are here today. And he will be conducting the hearing from this time on here, and also when we move out to Loretto this afternoon for the Vinland phase of the hearing.

Austin, welcome to Minnesota. We are glad you are here. We missed you, but somehow we have bumbled through. We have had good testimony, and you will be able to read it in the record. We are happy to have you here in Minnesota. I think you will find it is a pretty nice place.

Mr. **Murphy**. Thank you very much, Congressman Erdahl and Senator. I apologize for joining you late, and particularly to the witnesses who testified previous to my arrival. The planes and trains from Washington were traveling late this morning. They do what they want.

We are very concerned with H.R. 6820 introduced by Mr. Erdahl. This is the first of a series of hearings that the subcommittee has held on this legislation. Whether we will get full markup in this session of Congress may be doubtful, but we do intend to proceed with this bill rather expeditiously, and I am pleased to be here this morning and hold our first hearing in Minnesota.

Thank you very much. We will hear now from the next witness——

Senator **Boschwitz**. Mr. Chairman, if you would yield. As you know, I have introduced similar legislation in the Senate, and we indeed are going to try to go to markup in this session. I certainly would hope that the authorizing legislation could proceed rapidly during this session in the House as well. It is much-needed legislation, as you know.

Mr. **Murphy**. I appreciate that advice, Senator. Thank you.

The next witness is Norman Sellman, a parent of vocational technical students.

STATEMENT OF NORMAN SELLMAN, A PARENT OF VOCATIONAL TECHNICAL STUDENTS

Mr. **Sellman**. Thank you for coming to Minnesota this morning. My name is Norman Sellman. I live in White Bear Lake, Minn., a suburb of St. Paul. I work for a large industrial company in St. Paul. I am a parent of four deaf children. Two of my sons have graduated from St. Paul TVI, one son went to NTID-RIT, New York, and a daughter will be enrolled at St. Paul TVI this fall.

My oldest son, Alan, is profoundly deaf and attended TVI in the fall of 1969 through 1971. He enrolled in the carpentry and cabinetmaking course. This course was very complete for this trade. They built a complete small model house which gave them, the students, a background of the carpentry trade. On completion of this course he was placed in an apprenticeship program in the St. Paul area.

I am sure a lot of the counselors at TVI at that time had problems trying to get a deaf individual into the construction trade. There was a lot of work on their part to influence the powers that be and the labor market to accept him in the hardhat trades.

He completed his required hours in the apprenticeship program and was accepted in the trades as a journeyman carpenter. He has been very successful since that time and has been accepted in the trades as a very productive worker. I feel that his education at TVI has made him a successful wage earner. Many of his employers and fellow workers are surprised at the speed and accuracy of his work and the short time it takes for him to get familiar with the job he is assigned to work on.

My second son, David, enrolled at TVI in 1974. He enrolled in the graphic arts program. He graduated in 1 year and was placed with a large company in Bloomington, Minn. He worked for them 1 year and decided this job as a pressman was not what he wanted. TVI in St. Paul did not have photography courses, so he enrolled in Hennepin North in Brooklyn Park and took up photography which he enjoyed.

He was one of the first deaf students to take this course at Hennepin North. That year he won a first prize in a black and white photo of his sister that qualified him to go to Washington, D.C., to attend the national contest of VICA [Vocational Industrial Clubs of America] winners. TVI sent an interpreter along for this trip and it was a great experience for him to attend this national contest. He was later placed with a large company in Minneapolis and has been employed with them as process color finisher for the past 6 years. They are very satisfied with his progress and he performs all the duties that are required of him.

My third son, Daniel, graduated from Highland Park Senior High on the honor list and decided to attend NTID-RIT in New York. They had a hockey program for deaf students to compete in, so that is the drawing card for him to attend that school. He had several friends that attended that school for 3 years, and met many good friends from all over the United States. This was a great experience to live away from home and handle all the financial affairs that went with growing up, and being able to fly and make his own plane reservations was a great learning experience.

He graduated in June of 1981 just when the job market was very rough. He has been working through Jenny Kron and her services. He was able to get in with Cardiac Pacemakers for 3 months as a computer operator. This work experience has been very valuable for him. Since that time he has been active in "Twin Cities" deaf activities such as being manager of a softball team and now playing on a football team.

My youngest child, Lynn, will attend TVI this fall. She will take some prep courses in bookkeeping and accounting. We hope to transfer her to 916 Vocational School after a few quarters. This would make it more convenient for transportation because it is much closer to where we live in White Bear Lake.

All my children attended a day school in St. Paul and were able to live at home. They were taught the oral method for many years, but the trend changed to sign language as they entered junior high and senior high. High school counselors at Highland worked very closely with TVI to guide the children into a trade that was best suited for them. I feel that the education my two sons have received at TVI have made them very happy despite the handicap of being profoundly deaf. They both own property and a home and are able to compete with the hearing society.

Thank you for listening to me.

Mr. MURPHY. Thank you very much, Mr. Sellman.

[The prepared statement of Norman Sellman follows:]

PREPARED STATEMENT OF NORMAN SELLMAN, PARENT OF FOUR DEAF CHILDREN, WHITE BEAR LAKE, MINN.

Mr. Chairman: My name is Norman Sellman. I live in White Bear Lake, MN a suburb of St. Paul. I work for a large industrial company in St. Paul. I am a parent of four deaf children. Two of my sons have graduated from St. Paul TVI, one son went to NTID-RIT New York and a daughter will be enrolled at St. Paul TVI this fall.

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He was one of the first deaf students to take this course at Hennepin North. That year he won a first prize in a Black and White photo of his sister that qualified him to go to Washington D.C. to attend the National Contest of VICA (Vocational Industrial Clubs of America) winners. TVI sent an interpreter along for this trip and it was a great experience for him to attend this National Contest. He was later placed with a company in Minneapolis and has been employed with them as process color finisher for the past six years. they are very satisfied with his progress and he performs all the duties that are required of him.

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Thank you.

Mr. MURPHY. Ms. Jenny Kron, director of the handicapped placement program, AFL-CIO Human Resources Development Institute.

STATEMENT OF JENNY KRON, DIRECTOR, HANDICAPPED PLACEMENT PROGRAM, AFL-CIO HUMAN RESOURCES DEVELOPMENT INSTITUTE

Ms. KRON. Thank you for inviting me to testify this morning. I wish to speak in support of passage of H.R. 6820, title III, which would assure that deaf persons continue to receive the benefits of established postsecondary programs such as the one that St. Paul TVI is presently providing.

My work in job placement of the handicapped has involved me with members of the deaf community since our St. Paul program began in January of 1980. We have worked with 69 deaf or hearing-impaired jobseekers during this time; such clients now make up 26 percent of our caseload. In the past 14 months, we accepted 51 hearing-impaired deaf applicants and placed 25 of them into employment. Half of these placements were TVI graduates, all of whom were looking for their first job. Of the non-TVI placements, 83 percent had specialized training, apprenticeships, college degrees, or extensive work experience. In other words, 91 percent of the hearing impaired for whom we found work had job training. In addition, deaf TVI placements were more severely handicapped in that 70 percent of them were nonspeaking.

The deaf person faces severe barriers in obtaining employment in our hearing/speaking environment—the myth of "deaf and dumb" still exists—but lack of education or career training should not be one of those barriers. We cannot afford, morally or financially, to allow these healthy, intelligent members of our society to remain unemployed or underemployed because of lack of special postsecondary career training, which would allow them to live the full and productive lives to which they have a right in this country.

In today's work world, where minimum requirements for a janitor's job is a high school education, those who cannot communicate clearly must have additional skill training to be competitive for available employment. It is my experience that deaf persons who have had the benefit of attending the excellent program here at St. Paul TVI have been far more successful in achieving suitable employment than those lacking such training.

There is still a great deal of fear and reluctance in the business community to hire the deaf. I find employers are much more receptive if the job candidate has credentials from a qualified, respected vo-tech school such as St. Paul TVI.

I would like to share my testimony time with Mr. Bruce Mitchell, to allow him to tell you about his experience in hiring a deaf TVI graduate.

Thank you, Mr. Chairman.

[The prepared statement of Jenny Kron follows:]

PREPARED STATEMENT OF JENNY KRON, PLACEMENT SPECIALIST, AFL-CIO HUMAN RESOURCES DEVELOPMENT INSTITUTE [HRDI], HANDICAPPED PLACEMENT PROGRAM

Mr. Chairman: I wish to speak in support of the passage of H.R. 6820, Title III, which would assure that deaf persons continue to receive the benefits of established post-secondary programs such as the one that St. Paul TVI is presently providing.

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I would like to share my testimony time with Mr. Bruce Mitchell of Basic Industries, Inc., to allow him to tell you about his experience in hiring a deaf TVI graduate.

Thank you, Mr. Chairman.

STATEMENT OF BRUCE MITCHELL, PERSONNEL DIRECTOR, BASIC INDUSTRIES, INC.

Mr. MITCHELL. As a member of the business community and several other organizations and associations related to the manufacturing industry, I cannot emphasize enough the need for this program. It is necessary for this training and placement service to continue in existence at the St. Paul TVI. I have participated in many programs aimed at familiarizing guidance counselors from the State's high schools to encourage students to take training classes at their local TVI's. The future jobs in industry are for the trained, not the untrained. I have heard this spoken over and over at many seminars and lectures on the needs of the industries, that being the training and skills a student learns at the local TVI's to be prepared for their jobs in industry.

My first experience with this program was in October 1981 when I interviewed a deaf graduate from St. Paul's TVI. I was impressed with this man's educational background and knowledge and felt that he would make an excellent employee. I offered the man a job, which he accepted. I then informed his soon to be foreman of his new man. He became extremely upset and went into the company president's office complaining. He was vehemently opposed to the idea of a deaf employee, along with other members of our supervisory staff.

I informed them all that we as individuals and businessmen have a social and a moral obligation to employ this man as long as his qualifications were comparable or better than any other applicants. We have a duty as an employer to see that they have an equal opportunity for employment. That equality only exists, however, as long as they bring the same qualifications and educational backgrounds to the job as their competition. At this point industry becomes willing to invest more into the individual to improve his skills and knowledge.

This story ends 2 days later when the night foreman comes to me with the statement that his new employee is the best man he has ever had. In fact, the relationship develops even further, to the point of the two of them hunting together and sharing a family meal together. The foreman's children are learning sign language so they can speak with their new family friend.

We have him on computer-controlled equipment, and I felt that had it not been for his TVI training that he would not have been able to be this successful on the job, nor would he be working for us.

My next experience with this program was in February 1982. At that time I was looking for a janitor; I specifically wanted someone that would be content being a janitor for the duration of his employment with us. So many times in the past we would hire a janitor and they would get out in the shop and decide that they wanted to be a machinist. This created a lot of expense in training and turnover.

Again the handicapped placement program came to service for me. They were able to find a fellow that was capable of filling my needs. He is an employee that takes real pride in his work and does a job far beyond what was expected of him. Since he has started, we have received several good comments on the appearance of the outside of our building as well as the inside. It is a real pleasure to have employees like him.

These two employees have become real assets to the company, and the employees they work with have benefited greatly by the experience of working with them.

I have always felt that the handicapped have a special place in the business community and fulfill a vital service like any other member of the work force. But without these programs to provide the necessary training for these people, business will find it hard to be able to utilize these people to their full capacity and potential. Nor will their employability be as great with the business community.

As a taxpayer, I also feel that I'd much rather support an educational type program than a welfare oriented program. With the educational program, eventually the clients will become taxpayers themselves and we will see a return on our money invested in the program.

[The prepared statement of Bruce Mitchell follows:]

Prepared Statement of Bruce E. Mitchell, Technical Administrator, Basic Industries, Inc., New Brighton, Minn.

Good morning, my name is Bruce E. Mitchell, Technical Administrator for Basic Industries Inc. I thank you for inviting me here to this hearing and allowing me to testify on behalf of Title III of H.R. 6820.

As a member of the business community and several other organizations and associations related to the manufacturing industry, I cannot emphasize enough the need for this program. It is necessary for this training and placement service to continue in existence at the St. Paul TVI. I have participated in many programs aimed at familiarizing guidance counselors from the states high schools to encourage students to take training classes at their local TVI's. The future jobs in industry are for the trained, not the untrained. I have heard spoken over and over at many seminars and lectures on the needs of the industries, that being the training and skills a student learns at the local TVI's.

My first experience with this program was in October of 1981 when I interviewed a deaf graduate from St. Paul's TVI. I was impressed with this man's educational background and knowledge and felt that he would make an excellent employee. I offered the man a job, which he accepted. I then informed his soon to be foreman, of his new man. He became extremely upset and went into the company's president's office complaining. He was vehemently opposed to the idea of a deaf employee, along with other members of our supervisory staff. I informed them all that we as individuals and businessmen have a social and a moral obligation to employ this man as long as his qualifications were comparable or better than any other applicants. We have a duty as an employer to see that they have an equal opportunity for employment.

That equality only exists however as long as they bring the same qualifications and educational backgrounds to the job, as their competition. At this point industry becomes willing to invest more into the individual to improve his skills and knowledge.

This story ends two days later when the night foreman comes to me with the statement that his new employee is the best man he has ever had. In fact the relationship develops even further, to the point of the two of them hunting togather and sharing a family meal togather. The foreman's children are learning sign language so they can speak with their new family friend.

Since the man has worked for us we have trained him in on the most difficult jobs in the shop. I feel that had it not been for his TVI training that he would never had been able to be this successful, or possibly even had this job.

My next experience with this program was in February of 1982. At that time I was looking for a janitor, I specifically wanted someone that would be content being a janitor for the duration of his employment with us. So many times in the past we would hire a janitor and they would get out in the shop and decide that they wanted to be a machinist. This created a lot of expense in training and turnover. Again the Handicapped Placement Program came to service for me. They were able to find a fellow that was capable of filling my needs. He is an employee that takes real pride in his work and does a job far beyond what was expected of him. Since he has started, we have received several good comments on the appearance of the outside of our building as well as the inside. It is real a pleasure to have employees like him.

These two employees have become real assests to the company and the employees they work with, have benefited greatly by the experience of working with them.

I have always felt that the handicapped have a special place in the business community and fulfill a vital service like any other member of the work force. But without these programs to provide the necessary training for these people, business will find it hard to be able to utilize these people to their full capacity and potential. Nor will their employability be as great with the business community.

As a taxpayer, I also feel that I would much rather support an educational type program than a welfare oriented program. With the educational program, eventually the clients will become taxpayers themselves and we will see a return on our money invested in the program.

Mr. **Murphy**. Thank you very much.

Mr. **Lauritsen**. Mr. Chairman, excuse me for interrupting. We have one deaf person who is on the staff here at St. Paul TVI who would like to make a statement, with your permission. That staff person is Ms. Janahne McCready-Johnson, and she is ready now.

Mr. **Murphy**. All right. We have the time and we would be delighted to hear from her.

Are you going to read from the statement?

Mr. **Lauritsen**. Ms. Johnson will sign her presentation and Ms. Bouchet will voice interpret for her.

STATEMENT OF JANAHNE McCREADY-JOHNSON, ST. PAUL VOCATIONAL INSTITUTE

Ms. **McCready-Johnson**. Mr. Chairman, first let me tell you briefly who I am. My name is Jan McCready-Johnson. I was born deaf, as were my brother and sister. I grew up in a residential school for deaf students in Faribault, Minn. I am grateful for my wonderful parents and their excellent support while I was away from home attending school with my peers.

I now work here at St. Paul TVI with the interpreter training program, which is funded by the Federal Government. I live in Blaine, a suburb of Minneapolis, in the Sixth District.

I remember very well growing up feeling overprotected, frustrated, and inferior. I often felt part of a minority and was often bombarded by "You can't do it, you're deaf." I have also experienced discrimination while working for some companies. After I started working here at TVI in 1976, those feelings diminished.

How did that happen? At TVI I was allowed to utilize the support services made possible by Federal funding. We deaf people are truly grateful for these services. If not for the services, we all would still be "in the dark" and feeling inferior. I want you to know how happy I am, and that my life has become much brighter.

My involvement is now one of the best things in my whole life. Why is that? One of the support services, and the most important, are the interpreter services. This allows me to reveal the real me, and I now have the same rights to freedom of speech. I have the right to full communication with people who don't know sign language. Because of this privilege, I am treated as an equal.

Finally, I know it is OK to be deaf and I am a human being, too. Many of us deaf people are now more eager than ever to take classes in almost any school or university because of notetaking and tutoring services available. It is so much easier to utilize this type of service, as we don't have to assume the burden of watching the interpreter or the signing speaker and writing notes at the same time. We would need four or more eyes and more than one brain to do both tasks.

I am very proud of my accomplishments I have made while working here. They are made possible by the support services and I want to continue making more accomplishments throughout my life.

I have traveled extensively throughout the United States and have met all types of people in the field of deafness. The travel moneys were made available by Federal funding. I am pleased to tell you that the deaf community in Minnesota is at the top for knowledge and professionalism in deafness. The deaf community is very fortunate to have St. Paul TVI and to have funds available from the Federal Government in order to benefit greatly from workshops or conferences on deaf awareness and new information on deafness. It is very important that we keep up with information about deafness and educate the many ignorant people about deafness. The best thing for us deaf people is respect and a good understanding from the "Other World"—meaning the majority—the hearing world.

Many of us deaf people are pleased to recognize our own rights and the realization that we can use them the same as anyone else. Thank you, to you and others for your efforts in keeping the programs for deaf people running. It is the best thing for all of us deaf people.

Thank you for allowing me to speak to you.

[The statement of Ms. McCready-Johnson follows:]

PREPARED STATEMENT OF JANAHNE MCCREADY-JOHNSON, ST. PAUL TECHNICAL VOCATIONAL INSTITUTE

Mr. Chairman: First, let me tell you briefly who I am. My name is Jan McCready-Johnson. I was born deaf as were my brother and sister. I grew up in a residential school for deaf students in Fairbault, Minnesota. I am grateful for my wonderful parents and their excellent support while I was away from home attending school with my peers. I now work here at St. Paul TVI with the Interpreter Training Program which is funded by the federal government. I live in Blaine, a suburb of Minneapolis, in the Sixth District.

I remember very well growing up feeling over-protected, frustrated, and inferior. I often felt part of a minority and was often bombarded by "You can't do it . . . you're deaf." I have also experienced discrimination while working for some companies. After I started working here at TVI in 1976, those feelings diminished. How did that happen? At TVI I was allowed to utilize the support services made possible by federal funding. We deaf people are truly grateful for these services. If not for the services, we all would still be "in the dark" and feeling inferior. I want you to know how happy I am and that my life has become much brighter. My involvement is not one of the best things in my whole life. Why is that? One of the support services, and the most important, are the interpreter services. This allows me to reveal the real me and I now have the same rights to freedom of speech. I have the right to full communication with people who don't know sign language. Because of this privilege, I am treated as an equal. Finally, I know it is okay to be deaf and I am a human being, too. Many of us deaf people are now more eager than ever to take classes in almost any school or university because of notetaking and tutoring services available. It is so much easier to utilize this type of service as we don't have to assume the burden of watching the interpreter or the signing speaker and writing notes at the same time. We would need four or more eyes and more than one brain to do both tasks.

I am very proud of my accomplishments I have made while working here. They are made possible by the support services and I want to continue making more accomplishments throughout my life.

I have traveled extensively throughout the United States and have met all types of people in the field of deafness. The travel monies were made available by federal funding. I am pleased to tell you that the Deaf Community in Minnesota is at the top for knowledge and professionalism in deafness. The Deaf Community is very fortunate to have St. Paul TVI and to have funds available from the federal government in order to benefit greatly from workshops or conferences on deaf awareness and new information on deafness. It is very important that we keep up with information about deafness and educate the many ignorant people about deafness. The best thing for us, deaf people, is respect and a good understanding from the "Other World"—meaning the majority—the hearing world.

Many of us deaf people are pleased to recognize our own rights and the realization that we can use them the same as anyone else. Thank you to you and others for your efforts in keeping the programs for deaf people running. It is the best thing for all of us deaf people.

Mr. MURPHY. Thank you. Really I think all of you, of course, are preaching to we who are reformed. We are very supportive of handicapped educational programs across the board for all of your handicapped young people and older people. But the tenor of this hearing is, of course, to establish whether we will have individual authorizations for particular educational projects as distinguished from them going through the Handicapped Educational Act and its appropriations which remain, fortunately, last year substantial, and were not block granted. I guess I would want to ask your State director, Mr. Opheim, to answer why he believes that we should single out certain programs and how they can be more effective if they are treated as separate entities than if they are within existing legislation, and whether he believes they should be authorized for the duration of time that the House resolution and Senate bill state, 5-year authorizations, whether or not this might remove some competitiveness from our services and why you think they should be individually authorized.

Mr. **Opheim**. Mr. Chairman, I would like to respond to that. There were many issues in the question you presented. If I forget to respond to one or two issues, perhaps you might remind me of what I missed. I feel very strongly that this particular program at St. Paul ATVI and the other three individual programs need to be continued. One of the major reasons for that is being aware of a track record that they have established. This particular institution and program here has demonstrated such excellent leadership, and one of the results of the leadership and the impact of the program here has been to open up the doors of other ATVI's in this particular State and rank them into higher educational institutions as well.

The other thing that enters into the issue, I believe, is the fact that deafness, although we see very large figures here, still has to be considered a low-incidence population. I do not really think that it is economically feasible to establish a large number of these kinds of programs. I think it is much more economically sound to continue with an existing program or whatever might be desirable because of the low incidence of the population. In that way it makes it possible to perfect the training program that is in each of these institutions and allows these institutions to provide leadership to the other educational institutions that we hope ultimately will have their doors fully open to deaf people and able to provide the services that they need.

Mr. **Lauritsen**. Mr. Chairman, may I add to that?

Mr. **Murphy**. Yes.

Mr. **Lauritsen**. Maybe I could very, very briefly recite the history of these four regional educational programs.

Mr. **Erdahl**. If the chairman would yield, because that was a question I was going to ask, just to give the awareness——

Mr. **Murphy**. He is going to give you a statement of legitimacy by asking the question. I know him.

Mr. **Erdahl**. The question I was going to ask is because even though we are having the hearing in Minnesota, we are concerned with the other similar programs, and the question I was going to ask is, Could you expand a bit and tell how maybe they are similar to the one we are now in in Minnesota and where they might be different if you are aware of that?

Thank you for yielding, Mr. Chairman.

Mr. **Lauritsen**. Mr. Chairman, the programs began as research and demonstration programs back in 1968 and 1969. It was a very unique venture because we were jointly funded by Rehabilitation Service and the then Bureau of Education of the Handicapped. As we got into 1971 and 1972 we determined yes, this is a good thing. It is serving deaf people. That was the intent of the program. The people in the Bureau of Education of the Handicapped made it clear to us that our funding was going to cease in 1974. It was a 5-year program, that was it.

So we started going to Washington looking for other people to help us find funding to continue beyond June 1, 1974. We knocked on many doors, every door we could think of. We have recorded that. I have documented that if you would like that for information. The result of that is I ran into Marty Lavor, then working with Congressman Al Quie, and Al Quie came here in February 1974, and he as a Congressman from Minnesota saw fit to draft the legislation which is now known as section 625 of Education of the Handicapped Act.

Maybe persons in the administration would differ with me, but I still feel that the legislation was initially written for deaf people, and as we progressed from 1975 to the present time, the record will show that other kinds of programs or other kinds of handicapped students are receiving money from that legislation. I don't disagree with other handicapped groups having money, but I would like to see them bring their own money. We felt the original intent of this legislation was for deaf people. We feel very strongly about that.

As we enter now the mideighties and the middle chart, Mr. Chairman, the rubella children up there that are now becoming adults, there are significant numbers, the largest numbers of deaf students that have ever graduated from secondary schools are going to be graduating and a fair number of those students are going to have multiple handicaps. Those students need specialized programs that are in existence. I don't think you can go out and recreate programs like these; programs like these take time. It takes time to develop the staff.

The excellent interpreting services that we have this morning—there has been interpreting going on this morning for oral deaf people, for deaf-blind people and for people who are deaf. It takes time to develop that kind of relationship. The rubella bubble is big, real, it is here, it is not going to go away. If we don't serve them, they are not going to be served and they are going to become a welfare issue.

It will cost more to let that population go unserved than to serve. Mr. Chairman, I know that you are from the Pittsburgh area. I just wanted to emphasize that the four programs that we are talking about really do serve a national constituency. We do serve students from every State in the country. This program in St. Paul has served 66 students from the Pennsylvania area. There are two students here this morning from the Pittsburgh area, and Dee Courtney is one of our students, I think from Evandale.

Mr. ERDAHL. In a bipartisan spirit, we want to check and be sure they are registered to vote.

Mr. LAURITSEN. If the students from Pennsylvania would stand up?

Mr. MURPHY. Good morning. Are they from Evandale and——

Mr. LAURITSEN. And from Pittsburgh.

Mr. **Murphy**. In the city? Carrick.

Are they resident students here now?

Mr. **Lauritsen**. Yes. These students are in what we call our consortium program. They began their initial studies here in this building as preparatory students, and because they have unique majors. And Dee is going to do truck driving, which is unheard of for deaf people to do that, but that is one of the breakthroughs that we have made here. Since we don't do that training in this building we work with 32 other schools in the State. If we can't provide the training in this building, we provide it in what we call the consortium schools. The point I wanted to make is that the four programs that are functioning and have been functioning since the sixties do serve a national population, and when we add Gallaudet College, the National Institute for the Deaf, we do have six federally funded programs that could fairly well meet the needs.

We are going to be short, but to put these programs in open competition, we would feel comfortable about winning an open competition.

Mr. **Murphy**. You apparently have been winning in open competition.

Mr. **Lauritsen**. Well, we want to continue. I think you asked about the 5-year need. I think again the middle chart on the top indicates that need is going to be there for quite sometime. That doesn't quite take the 5 years, but we do see some of these, the students that are deafened because of rubella taking a longer time to go through training programs, and we are ready to make program modifications to serve those students.

Mr. **Murphy**. Thank you.

Mr. Erdahl?

Mr. **Erdahl**. I would have a question, thank you, Mr. Chairman.

Just as a point of reference, because we are under pressure in the Congress to look at balanced budgets and cost effectiveness and all the rest, you brought out, Mr. Lauritsen, startling figures about what you speculate are the tax revenues that have been paid by the people who have gone through your program and gotten into the job market pay.

Could you balance that out and make a comparison over, as you say, profits, and that is a good word to put in quotation marks, over what has been expended in taxpayer moneys to give people these skills and training? What is the ratio? Are we getting a return on other money?

Mr. **Lauritsen**. That would be line 4 on the chart, which is also in my written testimony, the Federal dollars to provide training, and then the last line indicates the percent of return. The actual figures are for the first 5 years, we actually received $767,000, and at that time the rate of return was 8½ percent. By the time we got to 1979, the Federal input of dollars was $2,500,000, and the profit had escalated to $3,800,000, and we are projecting, because all those people that were working are still out there and we are adding to those numbers, that number is going up every year.

Senator **Boschwitz**. Would you yield?

Mr. **Erdahl**. Of course.

Senator **Boschwitz**. Bob, I wondered if you had included anything in those figures for the savings that the Government has

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made for support funds that some of these people would otherwise be receiving in the social security system or other disability payments that the Government makes? Did you include that in your figure as well?

Mr. LAURITSEN. If you will allow me to get up for one moment, I just happened to have another chart. We prepared that information about 1 year ago using actual figures from this county here, and we did some percentage work as that chart will show. I can't see the chart, but I think there is a 25-percent unemployment rate and a 50-percent unemployment rate, and those welfare costs I think are quite self-evident. They skyrocket very, very rapidly. That chart, Mr. Chairman and Senator Boschwitz, is in the written testimony.

Senator BOSCHWITZ. In other words, in the event you were to add the welfare payments, those profit figures would soar?

Mr. LAURITSEN. Yes. I think you are talking a couple hundred million dollars if you add welfare costs and the loss of the profit for the four programs. The figures would become astronomical.

Senator BOSCHWITZ. These figures I see here are just 475 individuals in our immediate area?

Mr. LAURITSEN. Right.

Senator BOSCHWITZ. Thank you, Mr. Chairman.

Mr. MURPHY. Are they based on actual figures or is that just an approximation?

Mr. LAURITSEN. They were actual figures obtained from the Ramsey County Welfare Department, which is the county that the city of St. Paul is in. We did it for single families and married families, Mr. Chairman.

Mr. ERDAHL. We have had very good testimony again from this panel, and I think especially to have the combination of people who would be identified primarily as educators, the lady from the AFL-CIO, which I think shows a good spirit, the cooperation between the private sector in Minnesota, between the labor community, between the business community, and certainly then to have a parent who has gone through an experience, I am sure with some anguish at times, but certainly with justifiable pride for what your children have been able to accomplish when they were given a little extra help that was needed. I think that is what the program is about. We can talk about Congressmen and Senators and union firms and business representatives, but when we come right down to it it is the individual that can personally benefit from some of the treatment, the skills, the training, the education that we have had evidenced here today. I want to thank all members of the panel for being with us, because I think in a sense by your presence you summarize what it is all about.

Mr. MURPHY. Senator?

Senator BOSCHWITZ. Thank you, Mr. Chairman. I would like to ask Dr. Lauritsen, what percentage of the deaf, people who have deafness as their primary disability, graduate from high school at the present time?

Mr. LAURITSEN. Are you talking about——

Senator BOSCHWITZ. Nationally.

Mr. LAURITSEN. How many school leavers every year?

Senator **Boschwitz**. What percentage of people who are deaf graduate from high school?

Mr. **Murphy**. Or get a high school educational equivalent?

Mr. **Lauritsen**. We are talking about the reading and language level. How many deaf students graduate from high school. Persons who are born deaf and start through the elementary-secondary program, I think the number is around 3,500.

Senator **Boschwitz**. What percentage of people with deafness as their primary disability graduate from high school and go on to TVI or other postsecondary institutions?

Mr. **Lauritsen**. Ten years before our program started it was about 10 percent and that 10 percent went to Gallaudet College in Washington, D.C. Because of these programs, we now assist almost 90 percent.

Senator **Boschwitz**. Ninety percent go on to postsecondary?

Mr. **Lauritsen**. Right.

Senator **Boschwitz**. So one could say that more than 90 percent of the children who are born deaf graduated from high school and that 90 percent of them indeed go on to additional education?

Mr. **Lauritsen**. Right. That figure is almost the same as for hearing people, and that is what we are trying to do, provide the same opportunity for deaf persons as hearing persons have.

Mr. **Murphy**. That seems unusually high to me. I don't believe that 90 percent of the young people in our country are going on to postsecondary education.

Mr. **Lauritsen**. I am recalling a study done in Minnesota a number of years ago, and I would have to update that figure, and I will be happy to do that for you, Mr. Chairman.

Mr. **Murphy**. I think that it is important as to what percentage, where have we come and where are we going in education for the deaf and what is the percentage nationwide. We will direct our staff to get that for us, too, as to what percentage of the young people who are deaf nationwide are attaining a secondary education, and then from there, what percentage are going on to postsecondary.

Mr. **Lauritsen**. In the written testimony that we provided we do report on the results of a survey that we conducted this spring and people from the Library of Congress have asked about it, and you will find some data in the written testimony that you have.

Mr. **Murphy**. Thank you.

Senator **Boschwitz**. Bob, is there also data in the written testimony to show us the number of people who go to Gallaudet? I worked with kids one summer at a vacation hotel, in New York, and that is where they came from. Is there a number to show how many go to Gallaudet, how many come here, how many go to Seattle, New Orleans, and the other programs?

Mr. **Lauritsen**. We asked in the study how many would go to 2-year postsecondary programs, without having them name the programs, which students would go to 4-year programs, not having them name the programs, so we did not break it down.

Senator **Boschwitz**. I am very pleased to see a mutual friend of ours here, Jean Kelly, a member of my staff who took interpreter training. We recently promoted her in the office, not in interpreting because not many people come in who need an interpreter. I think she may have been motivated by a young lady from Gallaudet who worked on our staff. This hearing makes me think again that we have to get more handicapped people on our staff. It is a very enriching experience to me individually and to other members of our staff.

I thank you all for your testimony, all of which I have found very helpful.

Mr. **Erdahl**. Mr. Chairman, just as a comment, I want to thank the panel, too, and as I mentioned as we began the hearing today, before our chairman arrived, that we would be receptive to written testimony that any of you might have. Maybe some of you students have some things you wish to share with us, and I think the record will be kept open for a reasonable length of time to get that.

I think we are very close to our schedule. With your permission, Mr. Chairman, there might be somebody else in the audience who has come to either deliver a brief written or oral statement, and I would hope that if the time accommodated we could take that at this time. I am not sure anybody has. As far as we know all the people who have contacted our office have had the opportunity.

Is there someone here who might wish to do that?

Thank you very much, Mr. Chairman.

Mr. **Murphy**. With that, that will conclude this morning's hearing. The testimony of the witnesses I missed I will certainly read tonight as I enjoy my first evening in the Minneapolis area. I want to thank all of you, the participants as well as the spectators for being with us. We are going to journey on now to Vinland for the afternoon session.

[Whereupon, at 11:50 a.m., the subcommittee was recessed, to reconvene at 2 p.m., in the Vinland National Center, Loretto, Minn.]

HANDICAPPED INDIVIDUALS SERVICES AND TRAINING ACT

THURSDAY, SEPTEMBER 2, 1982

House of Representatives,
Subcommittee on Select Education,
Committee on Education and Labor,
Loretto, Minn.

The subcommittee met, pursuant to call, at 2:05 p.m., in the Stordahl Conference Center of the Vinland National Center, Loretto, Minn., Hon. Austin J. Murphy (chairman of the subcommittee) presiding.

Members present: Representatives Murphy and Erdahl.

Staff present: Cheryl Kinsey, majority staff member; Jane Baird, full committee staff; and Pat Morrissey, minority legislative associate.

Mr. Murphy. The hour of 2:06 having arrived, we will commence. We do all things in Congress promptly.

As chairman of the Select Education Subcommittee, I would like to welcome all of the witnesses to the second portion of our hearing today on the contents of H.R. 6820, the Handicapped Individuals Services and Training Act. This legislation was introduced by my colleague from Minnesota, Arlen Erdahl, and John LeBoutillier from New York.

Mr. Erdahl has been very supportive of programs for handicapped persons, and I appreciate this opportunity for careful examination of H.R. 6820 to determine its benefit for improving the effectiveness of these programs. This is the subcommittee's first hearing on this bill, and the insight gained through these hearings today will be invaluable to subcommittee members, many of whom were unable to be here today.

We will begin this portion of the hearing by taking testimony from Martin Adler, director of the Helen Keller Center, and Dr. Robert Smithdas, director of community education, Helen Keller Center. Since time is rather limited, the subcommittee may be submitting written questions to all witnesses, and we will also accept all following written testimony and include it as part of today's hearing record.

Mr. Adler, you may begin.

STATEMENT OF MARTIN ADLER, DIRECTOR, HELEN KELLER CENTER, ACCOMPANIED BY ROBERT SMITHDAS, DIRECTOR OF COMMUNITY EDUCATION

Mr. ADLER. Thank you, Mr. Murphy. Thank you for inviting us to testify before the subcommittee. I am the director of the Helen Keller National Center. My colleague, Dr. Robert Smithdas, director of community education, is the recipient of three honorary doctorate degrees, a poet and an author, and has been deaf-blind since the age of 4. I will use the 5 minutes to cover a tremendous area.

I will give a brief history of the Helen Keller Center, a description of our service delivery program and why we feel it is important for this bill to be passed, H.R. 6820.

Following enabling amendments to the Vocational Rehabilitation Act of 1967, the National Center for Deaf-Blind Youths and Adults was initiated in 1969 by agreement between the then Department of Health, Education, and Welfare and the Industrial Home for the Blind. The center was constructed with Federal funds in 1975–76, approximately 7,500,000 dollars' worth of Federal moneys for the construction of this rather unique facility in Sands Point, N.Y., located on Long Island.

We are currently and have always been supported by Federal funds, which is approximately 87 percent of our fiscal budget. Thirteen percent of the fees that we generate are from the different State vocational rehabilitation departments.

The center consists of three buildings on a 25-acre campus, not as beautiful as this, but quite attractive, with a headquarters staff of 110 professionals and residential facilities for 52 deaf-blind individuals during their rehabilitation program.

Every client admitted to the center must be both deaf and blind. We have clients from just about every State in the Union—Minneapolis, Minn., we have one right now, and we have I believe four or five from the State of Pennsylvania.

The service delivery system at headquarters provides for a complete diagnostic evaluation and determination of what rehabilitative services are necessary to enable the deaf-blind client to achieve his or her maximum potential. Deaf-blindness is regarded as the most severe of all handicaps, and services must be concentrated on a 1-to-1 basis. We provide training in communication, education, daily living skills, mobility, industrial arts, prevocational work, home and personal management, personal hygiene, sex instruction, speech therapy—I have a whole list, most of which is in the presentation.

When they complete work at headquarters they are referred back to their local communities. Our nine regional offices located in New York, Philadelphia, Boston, Chicago, Seattle, San Francisco, Denver, Atlanta, and Dallas then provide and work in developing a support system for our clients in providing work placement activities, work satisfaction activities, social activities that must go along with those work activities, because when our clients work during the day and come home and must literally face four walls without any means of communicating or becoming involved in the community, they soon lose the motivation to continue to work. We have had to train our own staff and we train the staff of many of the facilities throughout the country in how to work with deaf-blind. Nobody has been teaching this.

In June of this year we developed in concert with Western Maryland College the first deaf-blind master's degree program in deaf-blindness at Western Maryland in Westminster, Md. Our national training team goes throughout the country providing training, consultation, and support help to all of these agencies in learning and coping with working with the deaf-blind. Our research department has pioneered in the development of various aids and devices for the deaf-blind, including the very new and very exciting tactile communicator that provides radio developed signals for the deaf-blind so that they can connect these signals to the doorbell, a telephone or TTY, a fire alarm system, a burglar alarm system, and what Bob and his wife have done in their own home, they have connected it so that they have a call system. This way when one is in one room and the other person is in another room and they want to locate one another, in their five-room apartment when they want to locate one another, they press a button on their belt and this vibrates on the other person and they know where they are.

We have been able to develop a national delivery system, a national service delivery system, in a way that recently the Attorney General of the Department of Education gave us an outstanding 11-week audit report. That is on file, and we want you to see it.

The need for approval of H.R. 6820 is very obvious. Congressman Erdahl, this morning you raised the question or perhaps you did, Congressman Murphy, in terms of why should this be passed, why the independent nature. Allow me to go off my prepared speech to comment directly on that.

Mr. MURPHY. Taking into consideration that you are now receiving 87 percent of your total budget from the Federal Government, do you think you will do any better?

Mr. ADLER. We hope to do as well as that 87 percent, and hopefully better, but that 87 percent is fine. What has happened, because we are on a discretionary line item, the following situation occurred 1½ years ago. Congressman Natcher's subcommittee on appropriations appropriated $3.5 million to the HKNC. By the time it came through the RSA commissioner's office, through the Department of Education and through their "discretionary and approved methods of cutting back," our appropriation was $3.2 million, even though the subcommittee had said $3.5 million, because we are on that discretionary line item. Second, that discretionary line item indicates philosophically and fiscally that any one year our concept of an established center can be stopped, because it is a discretionary line item. That to us is the most important.

We are not even asking, believe it or not, for more money at this time. Our important goal is to get off what used to be called the research and development, the provisional, discretionary line item, and get on a permanent line that we do belong on. We are an established center, no longer a research center, no longer a demonstration center. Over 12 years we have demonstrated that the deaf-blind, people like Bob, some 120 have been able to receive jobs, one of which became the outstanding Federal handicapped employee of the year in 1980, a deaf-blind person who came to our center without any communication, without vocational skills; 18 months later the Philadelphia Navy Yard took him on. He is still working since 1979 and became the Navy's outstanding worker of the year and one of the 10 Federal handicapped workers of the year in 1980. That is one of the group. We have names, addresses. We have also a world renowned reputation of being able to produce, produce in an effective, efficient manner employment opportunities, independent living, return to society for our deaf-blind.

Thank you, sir.

Mr. MURPHY. Thank you very much.

[Materials submitted by Martin Adler follow:]

PREPARED STATEMENT OF MARTIN A. ADLER, M.S.W., A.C.S.W., DIRECTOR, HELEN KELLER NATIONAL CENTER FOR DEAF-BLIND YOUTHS AND ADULTS, SANDS POINT, N.Y.

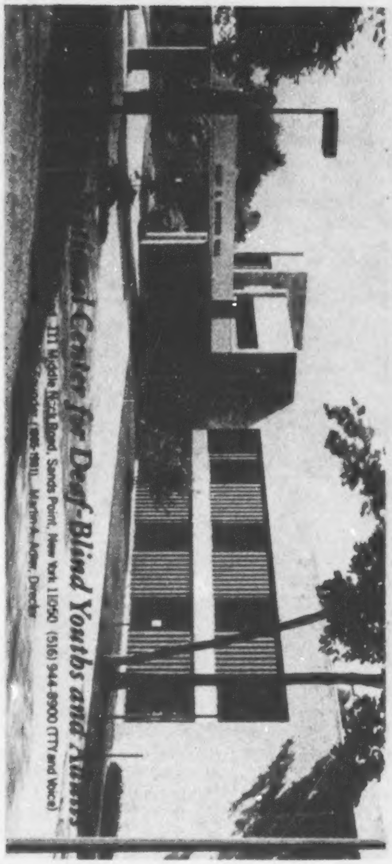
Mr. Chairman and Honorable Members of the Subcommittee: Thank you for inviting Dr. Robert J. Smithdas and me to testify before the Subcommittee. My name is Martin A. Adler and I am the Director of the Helen Keller National Center for Deaf-Blind Youths and Adults. My colleague, Dr. Robert J. Smithdas, who is the Director of Community Education at our Center, is the recipient of three honorary doctorate degrees, a poet and an author, and has been deaf-blind since the age of four.

I will first give a brief history of the Helen Keller National Center, a description of our service delivery program, and why we feel it is important that the Subcommittee approve H.R. 6820. Following enabling amendments to the Vocational Rehabilitation Act of 1967, the National Center for Deaf-Blind Youths and Adults was initiated in 1969 by an agreement between the then Department of Health, Education and Welfare and The Industrial Home for the Blind. The Center was contructed with federal funds (approximately $7.5 million) and is supported by federal funds (approximately 87 percent). The Center headquarters, located in Sands Point, New York, consists of three buildings on a 25-acre campus with a headquarters' staff of 110, and residential facilities for 52 deaf-blind individuals during their rehabilitation program. Every client admitted to the Center must be both deaf and blind, and we have had clients from just about every state in the union. The service delivery system at headquarters provides for complete diagnostic evaluation and determination of what rehabilitative services are necessary to enable the deaf-blind client to achieve his or her maximum potential. Deaf-blindness is regarded as the most severe of all handicaps and services must be concentrated on a one-to-one basis with every aspect of the program tailored to the individual needs of the client. We provide training in communication, education, daily living skills, mobility, industrial arts, prevocational activities, home and personal management, personal hygiene, speech therapy, audiological services, complete counseling opportunities, and many other services. When the clients complete their training at headquarters, they are referred back to their local communities. Our nine regional offices then provide work placement and/or other supportive services. We have funded some 22 agencies, thus establishing a network of affiliated agencies throughout the country which has provided additional support systems for the deaf-blind and their families. We have had to train our own staff and the staffs of other agencies to learn how to work with the deaf-blind and this is accomplished through our national training team. In concert with Western Maryland College, we developed the first master's degree program in deaf-blind rehabilitation. Our Research Department has pioneered in the development of various aids and devices for the deaf-blind, including a tactile communicator that provides radio lifesaving signals for the deaf-blind within their homes. We have been able to accomplish a national delivery system in an effective, cost-efficient and professionally responsive manner.

The need for approval of H.R. 6820 to us is quite obvious. Our Center, since its inception, has been funded as part of a category called "Service Projects" within the Rehabilitation Services Administration budget. This is a discretionary line item. We assume the original intent of placing our Center on the discretionary line item was to test out the validity of services to deaf-blind under one national agency. Some thirteen years have since proven that our Center has effectively and efficiently developed services for the deaf-blind, has become a national resource, and in fact is known throughout the world. We are no longer an experiment or a discretionary project. With a federal capital investment of close to $8-million and federal funding to date of almost $21-million and state income of approximately $2-million, we are not a temporary agency. Because of reductions in funding and discretionary leeway within the Department of Education, we have had to develop contingency plans to reduce aspects of our service delivery program. We feel that H.R. 6820 would provide a separate appropriation line item which would enable us to plan and provide services in a more stable, ongoing, and effective manner. Passage of H.R. 6820 would remove the "discretionary image" and would create a statutory authority for the Center similar to the existing and ongoing authority that established the American Printing House for the Blind, the National Technical Institute for the Deaf, Gallaudet College, and the Model Secondary School for the Deaf. The Center is the only cost-effective way of providing the intensive rehabilitative services necessary for the approximately 6000 young people who are deaf-blind as a result of the 1963-65 rubella epidemic and are in need of rehabilitative services. No state can be expected to duplicate the services because of the high cost involved in serving a relatively small population of deaf-blind persons in each state.

We respectfully urge the Subcommittee to approve H.R. 6820 which would, in effect, be saying to our deaf-blind citizens that the federal government cares and is sufficiently concerned in making sure that comprehensive services are available throughout the country.

Thank you.


al Center for Deaf-Blind Youths and Adults
111 Middle Neck Road, Sands Point, New York 11050 (516) 944-8900 (TTY and Voice)
Martin A. Adler, Director

"I only know
that when I touch
a flower, or feel
the sun and wind
upon my face,
or hold your hand
in mine, there is
a brightness
within my soul
that words can
never trace.
I call it Life,
and laugh with
its delight, though
life itself be out of
sound and sight."

–Robert J. Smithdas, L.H.D., Litt.D., L.H.D.
Director of Community Education

Helen Keller National Center
for Deaf-Blind Youths and Adults

Helen Keller National Center for Deaf-Blind Youths and Adults

Headquarters
111 Middle Neck Road, Sands Point, New York 11050
(516) 944-8900 (TTY and voice)

National Field Services Supervisor
National Coordinator of Affiliated Services
1111 W. Mockingbird Lane, Suite 1330
Dallas, Texas 75247 (214) 630-4936 (TTY and voice)

Service Regions

New England Region
89 State Street
Suite 1130
Boston, Massachusetts 02109
(617) 523-7171 (TTY and voice)
Connecticut
Maine
Massachusetts
New Hampshire
Rhode Island
Vermont

North Central Region
35 E. Wacker Drive
Suite 1268
Chicago, Illinois 60601
(312) 726-2090 (TTY and voice)
Illinois
Indiana
Iowa
Michigan
Minnesota
Missouri
Wisconsin

Southeastern Region
1001 Virginia Avenue
Suite 320
Atlanta, Georgia 30354
(404) 766-9625 (TTY and voice)
Alabama
Florida
Georgia
Kentucky
Mississippi
North Carolina
South Carolina
Tennessee

Mountain-Plains Region
12076 E. 45th Avenue
Suite 202
Denver, Colorado 80239
(303) 373-1204 (TTY and voice)
Colorado
Kansas
Nebraska
North Dakota
South Dakota
Utah
Wyoming

Mid-Atlantic Region
111 Middle Neck Road
Sands Point, New York 11050
(516) 944-8900 (TTY and voice)
New Jersey
New York
Puerto Rico
Virgin Islands

Northwestern Region
840 Strander Boulevard
Suite G
Seattle, Washington 98188
(206) 575-1491 (TTY and voice)
Alaska
Idaho
Montana
Oregon
Washington

East Central Region
P.O. Box 1036
Philadelphia, Pa. 19113
(215) 521-1370 (TTY and voice)
Delaware
District of Columbia
Maryland
Ohio
Pennsylvania
Virginia
West Virginia

South Central Region
1111 W. Mockingbird Lane
Suite 1330
Dallas, Texas 75247
(214) 630-4936 (TTY and voice)
Arkansas
Louisiana
New Mexico
Oklahoma
Texas

Southwestern Region
870 Market Street
Suite 953
San Francisco, CA 94102
(415) 956-4562 (TTY and voice)
Arizona
California
Guam, Samoa and the
Trust Territories
Hawaii
Nevada

Our Philosophy

Few handicaps are as completely isolating as deaf-blindness. At the **Helen Keller National Center**, we provide the necessary skilled support services and training opportunities that deaf-blind individuals need to manage their disability. With patience, understanding and experience, we enable our clients to return to their home communities with new skills and the possibility of employment.

Most importantly, we help the deaf-blind person to develop a sense of personal dignity along with the skills and conviction needed to face the future.

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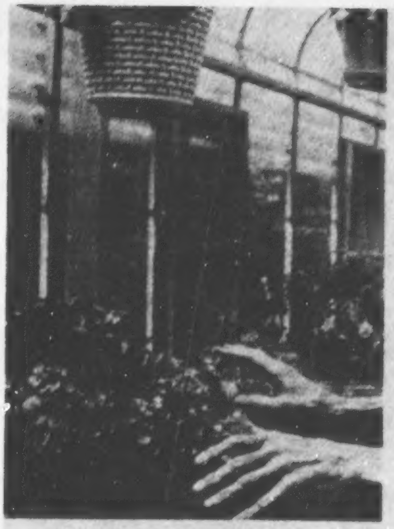

"I like this school because I went to school before and I never learned anything. Here, they take the time to teach me. I never learned signs or fingerspelling before, or how to cook. I never learned how to walk with a cane before. I also learned how to get along with people from institutions. They don't bother me, and I don't bother them, but I try to help them. The VA brought wheelchairs here, and I learned to take them apart and put them together. I'm attempting to read braille, something I never learned before."

—Client

"We appreciate the positive, encouraging attitudes which competent instructors practice toward building up self-images instead of tearing them down."

—Parent of Client

A client enjoys socializing with her new friends using Sign Language, one of the many communication skills taught at HKNC.

To develop and maintain the *National Register of all individuals who are deaf-blind* in order to provide information indicating the composition and distribution of the deaf-blind population, and to aid in planning of appropriate services.

To encourage and develop *research*, and to design and improve *sensory aids* to help reduce the handicapping effects of deaf-blindness.

To provide through a *National Training Team* in the field, and *Training Seminars* at headquarters, improved techniques of rehabilitation for workers delivering services to deaf-blind persons.

To provide *Community Education Programs* sensitizing both the public and professionals in the field to the very special needs and aspirations of deaf-blind individuals.

And to *encourage, educate and assist* public and private agencies and employers to develop and increase services for deaf-blind individuals.

Creating festive decorations in the Arts and Crafts department.

One aspect of the Home Management training is food preparation and meal planning.

An Industrial Arts Instructor observes a client safely operating a lathe in an industrial machine shop work setting.

The Program

Prior to acceptance, the Regional Representative assesses the appropriateness and readiness of a client to participate in the HKNC program.

Once accepted, a staff social worker focuses on the social, emotional and physical needs of the individual, communicates with the client's family, and assures a smooth and comfortable transition from home to the Center.

Upon admittance to the Center, a Vocational Rehabilitation Counselor works on a one-to-one basis with the client to help the person understand the evaluation process, and to plan an appropriate program of training. The Counselor also serves as the link between the sponsoring state agency and HKNC—reporting on the deaf-blind client's progress and future placement.

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National Objectives of HKNC

To provide *initial assessment* of physical and psychosocial functioning of deaf-blind individuals to determine feasibility for admission to HKNC, or to refer the individual to another agency whose services are most appropriate to meet their individual needs.

To provide *multidisciplinary evaluation* to those admitted to HKNC to determine their rehabilitation needs, interests and potentialities.

To then provide comprehensive individual *rehabilitation training* to achieve in each case (a) meaningful contact with the environment and effective means of communication, (b) constructive participation in the home and community, (c) initial or enhanced employability, and (d) any other development important to the optimum rehabilitation of the deaf-blind individual.

To act as a *resource center* for the deaf-blind, their families and friends, and professionals in the field who work with the deaf-blind.

A client assembles a ton plate unit in the Industrial Arts Department to develop transferable work skill.

Job Placement

Preparation for employment is a critical part of helping the deaf-blind person develop a sense of personal dignity and to realize his/her full potential. Many of our clients are capable of working in sheltered workshops and in unskilled competitive employment. Still others, because of their ability and motivation, successfully work in technical or professional jobs.

Once appropriate placement is developed, we provide mobility and orientation training to our clients in both work and residential settings, and monitor their on-going progress. Even after clients are placed, we remain active with them throughout their lifetime providing the necessary support, training, counseling and direct assistance to the client, the family, employer and referring agency.

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Through Orientation and Mobility instruction our clients can increase their scope of independence in their home environment and in the community.

- *A client travels confidently en route to a delicatessen in a local commercial area.*
- *Unlike a blind, hearing individual, who may cross streets by utilizing specific auditory techniques, a deaf-blind person must rely on public assistance for all crossings.*
- *If independent travel is to become a reality, an effective means of communicating with the public must be established. A client is using the "Tellatouch" device with a typewriter keyboard which converts a typewritten message to Braille form.*

"I've learned so much since I came here. I feel so much better about myself and my future. I feel happier now that I have more friends."

—Client

Eligibility

Eligibility for enrollment in the evaluation and rehabilitation program is limited to those who are deaf-blind within the following general definitions:

Deafness, a physiological chronic hearing impairment so severe that most speech cannot be understood through the ear with optimum amplification. A speech discrimination score of 40% or less in the better ear would generally indicate a hearing impairment within the Center's criteria for enrollment in the evaluation and rehabilitation program.

Blindness, visual acuity not exceeding 20/200 in the better eye with correcting lenses, or visual acuity greater than 20/200 if the visual field is constricted to 20 degrees or less. Exception to this basic definition may be made for a deaf-blind individual with an auditory or visual condition that shows poor prognosis, or one whose ability to use hearing and/or vision is so limited, as a result of protracted inadequate use of either or both of these senses, that the individual functions as a deaf-blind person. Some individuals with substantial visual and auditory deficits requiring a period of specialized training and practice to make optimum use of newly acquired high amplification hearing aids and/or special corrective lenses, may also be eligible.

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A deaf-blind Assistant Instructor in the Communication Learning Center (left) is pleased to have achieved a break-through with her client. They are communicating via the tactual manual alphabet.

Our prevocational training progam includes instruction in various communication skills; orientation and mobility; basic education; skills of daily living; home management; industrial arts; speech, auditory and low vision training; leisure activities; and a unique horticulture-therapy program. The psychology and medical departments provide additional services. All instruction is on an individual basis, allowing clients to progress at their own pace, until they are ready for job placement, or a future consistent with their personal interests and abilities.

Our goal is always the same: to help the deaf-blind individual develop a greater sense of personal dignity and conviction to face the future through improved self-sufficiency, with the greatest degree of independence possible.

[illegible] Department

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The Center's Speech Pathologist works with a client on the "Vibrating Floor." This steel floor is housed in a soundproof room and is set into vibration via live voice, amplified by a microphone, and recorded music. The floor converts sound into vibrotactile cues enabling hearing-impaired persons to feel some of the components of speech—as rate and volume, pitch of voice and duration of sound. Here the client is learning and is being encouraged to produce vocalizations in imitation of the therapist and gradually by himself.

Sewing is a skill taught in Daily Living Skills to maintain proper management of wardrobe.

> ***"I feel it is very important for people who are deaf and blind to learn mobility, cooking, and other skills of daily living; also to develop their minds to their best ability."***
>
> —Client

Woodworking is an integral part of the Industrial Arts Program.

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Our Center

Established in 1967 by a unanimous act of Congress, the Helen Keller National Center for Deaf-Blind Youths and Adults, a comprehensive rehabilitation, research and training facility, is operated by The Industrial Home for the Blind.*

Our headquarters is located on a 25 acre site in Sands Point, Long Island. Our staff consists of dedicated professionals, technicians, support personnel and community volunteers. The Center has been expressly designed to serve the deaf-blind population. The training, research and administration building, along with the Peter J. Salmon residence (where our clients make their temporary home) are equipped to meet their comfort, accessibility and safety needs.

Working with our nine Regional Offices (listed in the back) and Affiliated Agency Programs, we operate an extensive nation-wide Network of Field Services.

The nine Regional Offices provide consultation and direct assistance to state and local agencies serving the deaf-blind in their home communities. The Regional Representatives locate, assist and refer deaf-blind persons to the most appropriate program for services, help to resettle clients, seek employment opportunities, and advocate for services for all deaf-blind individuals.

The Affiliated Agency Programs are public or private agencies that receive temporary financial assistance from HKNC to develop and/or expand services for the deaf-blind population throughout the country.

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*The authorization for its operation is contained in Section 313, Title III of the Rehabilitation Act of 1973, as amended, and funds for its operation are appropriated annually by Congress. It operates under the general supervision of the Rehabilitation Services Administration.

[illegible]

The life of a deaf-blind person is enriched with the understanding and nurturing of plants through the HKNC horticulture therapy program. A job in a greenhouse or nursery is a possible vocational goal for some clients.

Help is Available

If you know of a deaf-blind youth or adult who is in need of assistance, contact your Regional Office of the Helen Keller National Center. The Center's regional representative will provide, at no cost, immediate help and consultation.

Fees

Fees are charged to sponsoring agencies for evaluation, rehabilitation training, and room and board for clients enrolled at the Center. These fees meet only a small part of the cost of the services provided.

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*"The best
and the most
beautiful
things in the
world cannot
be seen or
even touched.
They must
be felt with
the heart."*

–Helen Keller

Helen Keller National Center
For Deaf-Blind Youths and Adults

PETER J. SALMON, LL.D., Founder
MARTIN A. ADLER, MSW, ACSW, Director

operated by
THE INDUSTRIAL HOME FOR THE BLIND

September 22, 1982

The Honorable Austin J. Murphy, Chairman
Congress of the United States
House of Representatives
Committee on Education and Labor
Subcommittee on Select Education
617 House Office Building Annex #1
Washington, D.C. 20515

Dear Congressman Murphy:

We are replying to your correspondence of September 7, 1982 regarding information that you have requested from our facility regarding H.R. 6820.

May we first comment that we were very pleased and honored to have had an opportunity to meet before you and Congressman Erdahl. The Subcommittee staff was extremely helpful to us in preparing our testimony.

Our attached responses will first include the Subcommittee's questions. Please do feel free to request clarification of those points that may need further amplification or any additional questions or suggestions that may arise.

Sincerely,

Martin A. Adler, MSW, ACSW
Director

MAA:bf
Encl.

HEADQUARTERS: 111 Middle Neck Road, Sands Point, N.Y. 11050 • Tel: (516) 944-8900 (TTY and voice)

REGIONAL OFFICES

Mid Atlantic Region – Sands Point, N.Y.
New England Region – Boston, Mass.
East Central Region – Philadelphia, Pa.
Southeastern Region – Atlanta, Georgia
North Central Region – Chicago, Illinois
South Central Region – Dallas, Texas
Mountain Plains Region – Denver, Colo.
Northwestern Region – Seattle, Washington
Southwestern Region – San Francisco, CA

HELEN KELLER NATIONAL CENTER FOR DEAF-BLIND YOUTHS AND ADULTS

(1) How many deaf-blind persons are there in the U.S. and about what percentage of this population does the Helen Keller National Center serve?

There are a number of definitions as to what constitutes deaf-blindness. The generally accepted definition of legal blindness is that "visual acuity does not exceed 20/200 in the better eye with best correction or visual acuity greater than 20/200 if the total field of vision is constricted to 20 degrees or less." Basically, a client for Helen Keller National Center for Deaf-Blind Youths and Adults must be certified as legally blind by the state in which he resides. The definition of deafness has far greater variability and is not uniformly accepted throughout the country. The Regional Centers for Deaf-Blind Children generally define a deaf-blind individual as one whose combined visual and auditory losses are so substantial as to cause extreme difficulty in learning. Our basic definition of deafness is that the individual must have a physiological chronic hearing impairment so severe that most speech cannot be understood through the ear with optimum amplification. For your further information regarding general information and eligibility, please refer to our attached "Procedures for the Referral and Admission of Clients to the Helen Keller National Center." (A)

Based upon our definition of deaf-blindness, we developed a National Register of Deaf-Blind Youths and Adults. This register, consisting of 5,389 names, is on computer tape and, of course, is protected through the various systems of confidentiality. We recently added 3,837 names of deaf-blind children as part of a cooperative agreement with the Regional Centers for Deaf-Blind Children. This figure of 9,226 does not include all of the deaf-blind. We have estimated that there are approximately 20,000 to 30,000 deaf-blind individuals throughout the United States, its territories and possessions. This figure is based on a growing population of geriatric individuals who are losing both sight and hearing. There are some 6,000 rubella children who were born deaf-blind. Persons with a genetic disability called "Usher's Syndrome" (individuals who are generally born deaf and by their mid twenties have also lost their sight) also number in the several thousands. Thus, we come to the figure of 20,000 to 30,000 deaf-blind individuals.

Our nine regional representatives provide direct service to approximately 700 or 800 deaf-blind individuals per annum around the country. Our headquarters unit located in Sands Point, New York provides intensive residential on-site rehabilitative services for approximately 135 deaf-blind individuals throughout the year. I would estimate that HKNC serves between 3% to 5% of the deaf-blind population each year. In our efforts to increase that impact we recently developed our national training team (NTT) and consolidated the national affiliation network system. Briefly, the NTT provides training and consultation around the country to agencies in relation to deaf-blindness. Over the past several years, the affiliation network has and is servicing twenty-two agencies. We have provided them with start-up funds for a period of from three to five years to develop services for the deaf-blind. Thus, a national system of meeting the needs of some of the deaf-blind has been developed by our agency.

(2) What are the ages of your clients? Would that change under the new legislation?

We generally accept clients between the ages of 17 and 65 at headquarters.

During the current reporting year, 33% of our clients were between the ages of 21 and 30. The youngest was 17 and the oldest 63. Our regional representatives in the field work with any client who is deaf-blind regardless of age. The legislation under H.R. 6820 has not changed the age category of our existing eligibility.

(3) What is the process of referral to the Center? Do your clients come from rehabilitation agencies? from schools?

The process of referral to our Center is relatively simple. The individual must be deaf-blind, must be able to maintain personal hygiene and must have some motivation to use the services offered at the Center. (May we again refer you to Attachment "A.") Most clients do come from state vocational rehabilitation agencies. Referrals have come from private individuals, schools, hospitals and other facilities.

(4) Are there any referral choices other than to Helen Keller? Are there any state or private facilities anywhere in the country which provide services similar to those provided at the Center?

In an effort to expand the service delivery program for deaf-blind individuals throughout the country, we have provided initial funding for some twenty-two agencies to develop services for the deaf-blind. However, most of these agencies have one staff person who provides the services at that particular agency. Usually, that staff person is trained at HKNC. There is no facility in the world that has the physical equipment and concentrated numbers of staff that we have at HKNC. Our total staff complement is 127 individuals. Our three buildings and equipment cost approximately $9 million (1976 cost). Thus, to answer your question as to "similar" services, we unabashedly state that there is no other facility in the country that provides similar and comprehensive services.

(5) If referrals come from agencies, do those agencies pick up any of the cost of sending the client to Helen Keller?

The federal allocation enables us to provide services at an exceptionally low cost to the referring agency. This federal subsidy allows us to charge $90 per week for room and board, $100 per week for evaluation, and $90 per week for rehabilitation training. Most state vocational rehabilitation agencies regard the deaf-blind individual as a "high-risk rehabilitation client." Many state VR agencies are reluctant (particularly now) to use scarce rehabilitation monies for high-risk clients. Even though our rate of rehabilitation is relatively high, we have found that we must keep the fees to referring agencies at substantially below-cost in order to encourage these agencies to "take a chance" and refer deaf-blind individuals.

(6) Section 313 of the Rehabilitation Act, the current authority for Helen Keller, requires, to the extent feasible, that Helen Keller seek to recover from states, private insurers and other participating public and private agencies the cost of services provided. H.R. 6820 eliminates this requirement. What will be the effect, if any, of taking out this requirement?

We are not quite sure how or where H.R. 6820 eliminates the requirement of HKNC seeking to recover funds for providing services to deaf-blind individuals. We will continue to seek to recover the cost of services for our clients from state VR agencies or any other source that could provide third party payment. If it pleases the Subcommittee, we would have no objection to a provision being included under H.R. 6820 mandating HKNC to seek third party payment for services rendered.

(7) What is your total funding now, including both the Center and its regional offices? Is the $3.2 million you receive now under Section 313 the total amount of federal funds that Helen Keller receives?

We currently receive $3,137 million for Federal FY-82. In Federal FY-81 we received $3.2 million. The above figures are our total federal funding package. From these funds and third party payments we operate the total service delivery system which includes headquarters, the nine regional offices, NTT, and our affiliation network system. We have not yet been informed as to what our Federal FY-83 funding figure will be.

(8) What are the major sources of your non-federal funding?

Our major source of non-federal funding comes from the state VR agencies, as indicated above.* Some private monies are donated to the Center and generally average about $10,000 per year. These funds are used to meet expenditures not covered under our federal agreement, e.g. an arts and crafts classroom for leisure activities for our clients, emergency financial assistance for some clients, and a fragrance garden donated by the local garden club. Some clients and/or their families are able to pay some part of their room and board.

(9) What proportion of the Center's budget is allocated to "administrative" as opposed to "service" functions? (We do not mean to include counselor or teacher salaries in the category of "administrative" cost.)

(9) What is the relationship, if any, between the Helen Keller program and the Deaf-Blind Centers funded under the Education of the Handicapped Act?

Administrative functions are 9.92% of our overall budget for our current fiscal year (July 1, 1982 to June 30, 1983). The relationship between HKNC and the Regional Centers for Deaf-Blind Children, which is funded under the Education of the Handicapped Act, has always been cooperative. Mr. Robert Dantona, the former Chief of the Regional Centers for Deaf-Blind Children program in Washington was and still is a member of our National Advisory Committee. We have been involved in numerous cooperative conferences, workshops, and other professional activities with the Regional Centers for Deaf-Blind Children staff. Our separate national registers were recently merged to become the Helen Keller National Center Register of Deaf-Blind Persons. Children graduating from the Deaf-Blind Centers are referred to our facility for further training.

(10) Section 313 presently requires the Helen Keller Center to demonstrate methods of providing rehabilitation services to deaf-blind individuals. H.R. 6820 would change the requirement to one of conducting demonstrations with respect to teaching methods. This appears to downgrade the demonstration function of the Center. How would you describe the current demonstration function of the Center, and how would it differ under the provisions of H.R. 6820?

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* Anticipated program income from state VR agencies for Federal FY-82 (HKNC Fiscal Year July 1, 1982-June 30, 1983) will be $287,000.

Because HKNC was a new program and services to the deaf-blind population had to be proven, Section 313 required HKNC to demonstrate that deaf-blind individuals could receive and favorably respond to rehabilitative processes. The proof of our abilities and the response of deaf-blind individuals is now well-established and accepted by state VR agencies and RSA in the Department of Education. H.R. 6820 would require us to do what we are already doing, i.e. to demonstrate, to teach, and to impart to others around the country the rehabilitative techniques we have developed. We do not see this as downgrading the demonstration function. In fact, H.R. 6820 implies that we have in place and functioning our NTT, the affiliation network system, and all of the other methods we have implemented in demonstrating to the rest of the country (and incidentally to numerous other countries around the world) our research, our rehabilitation methods, and the overall service delivery system.

(11) Does the above change alter in any way the national scope of the Helen Keller Center?

As we indicated above, H.R. 6820 enhances the national scope of HKNC and provides for the necessary stability that will allow HKNC to develop long-range programs in a more systematic fashion.

(12) Please clarify the relationship that exists between the Industrial Home for the Blind and the Helen Keller Center. Do they have separate boards of directors, separate funding sources, etc.?

The Industrial Home for the Blind (IHB) is a well-known and respected agency that provides services for the blind and the deaf-blind for residents of Brooklyn, Queens, Nassau and Suffolk Counties. The Board of Trustees of IHB operates both the local service delivery program of IHB and the national program of HKNC. The Director of IHB is responsible for those local services operated by IHB. He is responsible to the Board of Trustees. The Director of HKNC is also responsible to the Board of Trustees of IHB and directs the national programs of HKNC. Thus, we operate under the same Board but have completely separate funding sources and separate accounting/administrative departments to handle the separate funding sources. HKNC is not a corporate body and operates under the corporate charter of IHB. The original and current Agreement with the Department of Education is with IHB.

(13) The Administration proposed last year to block grant all Rehabilitation Act programs, including Helen Keller, and this year proposed including Helen Keller in a discretionary block grant within the Department of Health and Human Services. What would be the likely impact of either of these proposals on services to the deaf-blind?

Block grant funding as proposed by the Administration would have a devastating impact on rehabilitative opportunities for deaf-blind persons throughout the country. Because of the expenditures necessary to implement a program for deaf-blind people and the scarcity of even adequately trained professionals who know how to communicate and work with deaf-blind people, state services for the deaf-blind would be at best minimal in quality and, I am sure, in some states non-existent. The incidence of deaf-blindness in some states is low and a separate program for that population would not exist. No state would allocate scarce funds for research, for the development of aids and devices, and probably a minimal amount of money for training of personnel. It would be questionable how much communication and transfer of skills and knowledge would exist between different states. Finally, because the deaf-blind are a small population, limited in its communication skills and certainly without political and numerical clout, funding for deaf-blind services would soon disappear in favor of other more vocal and politically active handicapped groups.

(14) In FY 83 your Section 313 funds were cut from $3.5 to $3.2 million as a result of the 4% cut in the Continuing Resolution. In what part of your program budget did you make cuts to reflect that reduction?

In Federal FY-80 we had received $2.5 million from the federal government. We proposed for Federal FY-81, an expansion program that highlighted an NTT, an affiliation network system, the opening of two additional regional offices, and an increased service delivery system. We never received the $3.5 million although it had been recommended by Congressman Natcher's Subcommittee on Labor, HHS, Education, and Related Agencies. Instead, we received $3.2 million for Federal FY-81. With the funding, we developed and expanded the affiliation network system, developed a limited but still effective NTT, opened one regional office, and tightened our own internal systems in order to accomplish some of the other goals. The Federal FY-82 budget of $3.137 million imposed further restrictions on the affiliated network system, restricted travel for the NTT, and administration has had to develop plans for the probable termination of some HKNC personnel toward the end of the 1982 calendar year and/or beginning 1983. Wherever possible, direct service personnel retain the highest priority in terms of tenure at HKNC. We have yet to be informed of our Federal FY-83 budget. We have requested a no-growth and no expansion budget of $4 million for Federal FY-83. That $4 million will enable us to continue to do what we are currently managing.

HELEN KELLER NATIONAL CENTER
For Deaf-Blind Youths and Adults
111 Middle Neck Road
Sands Point, New York 11050
Tel: (516) 944-8900 (TTY and Voice)

PROCEDURES FOR THE REFERRAL AND ADMISSION OF CLIENTS TO THE HELEN KELLER NATIONAL CENTER

Effective October 1, 1981

I. GENERAL INFORMATION

The Helen Keller National Center is located on a 25-acre campus in a suburban area on Long Island, New York. The three buildings that constitute the Center are newly constructed, utilizing all specially designed features that are necessary for accessibility, comfort, convenience, and safety of the trainees. The Peter J. Salmon residence building, where the trainees share air-conditioned twin bedrooms with private baths, is attractively furnished. This building contains many conveniences that afford pleasant and varied social and recreational activities during leisure hours. The Mary E. Switzer training building is also especially designed for safety, comfort, and convenience and contains rooms for classes, counseling offices, general medical and nursing offices which include ophthalmological and dental services, rooms for audiological testing, a gymnasium, and other areas that provide support services and research activities. A third building contains our automobile maintenance shop and greenhouse.

The program at the Helen Keller National Center includes instruction in various communication skills, mobility, basic education, skills of daily living, home management, industrial arts, speech training, and leisure activities. Our staff includes physicians and nurses, low vision specialist, dentist, audiologist, speech pathologist, psychologist, psychiatrist, social workers, rehabilitation counselors, instructors, residence personnel, and other specialized, trained individuals necessary to provide a total rehabilitation program for our deaf-blind trainees. A program offering placement for qualified trainees in various levels of sheltered or competitive employment is also included in the total rehabilitation program.

The Helen Keller National Center conducts broad programs of research, training for new and prospective professionals in service for deaf-blind individuals, the development of a national register of deaf-blind youths and adults, and community education. The Center operates eight regional offices, each staffed by a full-time professional representative who visits the home communities of prospective trainees and their families to acquaint them with the Center. The representative provides consultation and community education for agencies and communities interested in learning about available resources to help deaf-blind individuals. In addition, the Center encourages and financially assists selected agencies to develop services for deaf-blind youths and adults in local communities.

II. REFERRAL PROCEDURE

Referral of an applicant for service at Helen Keller National Center should be made directly to the Intake Coordinator, Helen Keller National Center, 111 Middle Neck Road, Sands Point, N.Y. 11050. A copy of the referring letter should also be sent to the Regional Representative serving the region in which the applicant resides. (Please see the attached P. 6, Service Regions, for the names and addresses of the Regional Representatives and the region each of them serves.) With a few exceptions, deaf-blind individuals served at the Center are sponsored by their respective state rehabilitation agencies. Any agency or private individual who may wish to refer a deaf-blind youth or adult to the Center is advised to first contact the state rehabilitation agency to determine the procedures followed by that state rehabilitation agency in initiating sponsorship of an individual at the Helen Keller National Center.

A detailed information packet is to be completed as fully as possible in order to enable the Helen Keller National Center to determine the eligibility and the rehabilitative potential of the deaf-blind individual being referred. This information packet could be obtained from the Regional Representative, who can be of assistance in completing the information forms.

When the completed information packet is received at the Center, the Intake Committee reviews the information and determines eligibility for service at the Center. The Intake Committee may request additional information or clarification of some of the information submitted. Once the information has been fully evaluated and accepted, a mutually convenient date will be set for the applicant's admission to the Center. In the event that the application is not accepted, the referring source will be advised of the reason for the Center's decision, and other resources that might be able to serve the applicant may be suggested.

Occasionally, a deaf-blind person presents behavioral or other problems which make the trainee's continuation at the Center impracticable. When this occurs it is the responsibility of the referring agency and/or the family to return the trainee to that person's permanent residence as soon as the staff of the Center decides that such action is necessary. Prompt return of any trainee to the permanent residence is also necessary upon completion of training at the Center. The residence of the Helen Keller National Center cannot be used for custodial care, as such a practice would needlessly restrict the availability of comprehensive rehabilitation services for other deaf-blind individuals who need such services.

III. REQUIRED MINIMUM FUNCTIONING ABILITY

In order to be considered for rehabilitation evaluation and/or training at the Center, an applicant must meet the following minimum functioning requirements: (1) Must be able to meet bowel and bladder elimination needs, to shower and/or bathe, wash, dress, and eat meals with sufficient reliability and competence to satisfy minimum health and personal hygiene needs; (2) must be free from violent behavior that might threaten the trainee's safety or the safety of others; and (3) must indicate some desire to make use of the services offered at the Center and be willing to temporarily live away from his/her accustomed environment; or, the applicant should be free from fear or strong resistance to entering the Center.

Low functioning ability will not preclude admission to the Helen Keller National Center, provided the foregoing conditions of eligibility are satisfied; but deficient mental capacity or mental illness which is so severe as to prevent significant learning will constitute a basis for terminating a deaf-blind person's enrollment at the Center.

Therefore, if it is known that an applicant lacks the capacity to learn, he should not be referred as a candidate for admission to the Center.

IV. REQUIRED MEDICAL INFORMATION

A. (1) A report from an ophthalmologist or optometrist, based on an eye examination administered within one year prior to the date of referral to the Center, showing that the applicant's visual acuity does not exceed 20/200 in the better eye with best correction or visual acuity greater than 20/200 if the total field of vision is constricted to 20 degrees or less with certification by the appropriate agency of the state in which the applicant resides that the applicant is classified as "blind;" or (2) a similar ophthalmological or optometric report showing the applicant's visual acuity and fields of vision with a certified statement that the applicant is blind within the meaning of the law relating to vocational rehabilitation in the state in which the applicant resides. Attention should be called to any physical activity or environmental condition that may be contraindicated by the applicant's eye condition. Required medication and any recommendation related to the care of the applicant's eyes should be described in detail. If the applicant is approved for admission to the Center prescriptions for any medication required should be submitted prior to admission.

B. The applicant must have a physiological chronic hearing impairment so severe that most speech cannot be understood through the ear with optimum amplification.

The client's hearing should be examined by an otologist or an audiologist. The primary information that will be considered in making a determination of eligibility will be related to the individual's inability to understand speech auditorily under optimum conditions. A speech discrimination score of 40% or less in the better ear would generally indicate a hearing impairment within the Center's criteria for enrollment in the evaluation and rehabilitation training program. An otological examination is required when a medical problem is present.

If a hearing examination by an otologist or an audiologist is definitely not available, then a statement is necessary from the applicant's physician or a professional worker who has firsthand knowledge of the applicant's auditory ability that the applicant is unable to understand connected speech through the ear with optimum amplification in a normal acoustical environment.

Consideration for admission to the Center may also be given (a) to an auditorily and visually impaired applicant who has a prognosis that suggests imminent loss of hearing and/or sight sufficient to render him eligible to the Center's evaluation program in order to prepare the applicant for the ultimate loss of both; or (b) to an applicant whose condition does not satisfy these criteria but who, because of the unavailability to him of appropriate amplification, accessibility of other appropriate agency assistance and/or training, has functioned as a deaf person with highly limited use of aural/oral communication; or (c) to an individual who cannot respond to a standardized speech discrimination test but who attains a pure tone average of 70 dB or more, indicating a severe physiological chronic hearing impairment.

C. A report of a medical doctor based on a recent comprehensive examination including the following (current to within 6 months of submission):

(1) Medical History: Past illnesses, treatments, medications.

(2) A description of any condition of the client, in addition to deaf-blindness, and the details of the attention required.

(3) Precise information on any medication required by the client (including prescription, where indicated; individual dosage; method and schedule of administration).

(4) Since all trainees reside in a dormitory setting we must have a physician's report that the client is free from any communicable disease.

NOTE: The physician's report should be accompanied by or should include the results of a recent chest x-ray, urinalysis, blood serology, a complete blood count on people over 30 years old, and a stool specimen report for ova and parasites. An Australian Antigen is required for those who have resided in institutions within the past year.

(5) Any information that the physician may feel could be helpful in promoting the safety and progress of the client, and identification of any physical activity, exercises, or environmental condition that might be contraindicated for the client.

D. When the client has additional physical or emotional problems, a report from the appropriate specialists or treatment facilities should be included (the physician, psychiatrist, psychologist, social worker, the certified therapist directly working with the person on the particular problem).

V. PERSONAL SKILLS AND BEHAVIOR REQUIREMENTS

The applicant must be capable of self-care in the areas of basic personal hygiene, e.g., toilet independently, bathing, dressing, and eating (though not necessarily with utensils). The applicant should not exhibit behavior which would be harmful to self or others, i.e. assaulting others or setting fires.

VI. REFERRAL SUMMARY

A summary of the client's educational, vocational, and social background, in as much detail as possible, is to be submitted with the counselor's request for service. The counselor should include social and developmental history, psychological, psychometric, or other available pertinent reports.

VII. INTAKE PROCEDURE

THE APPLICATION FOR ADMISSION MAY BE ATTACHED TO THIS INFORMATION PACKET. IT MAY ALSO BE OBTAINED FROM THE

INTAKE COORDINATOR
HELEN KELLER NATIONAL CENTER
111 MIDDLE NECK ROAD
SANDS POINT, NEW YORK 11050

OR FROM THE REGIONAL REPRESENTATIVE IN YOUR GEOGRAPHICAL AREA. PLEASE SEE PAGE 6.

All material and the completed application forms should be sent to the attention of the Intake Coordinator at the Helen Keller National Center.

The Intake Committee reviews all the information, and may ask for clarification of a possible problem area. When all questions are answered and the person is medically cleared, a date is set for admission.

VIII. FEES FOR SERVICE

The schedule of all fees at the Helen Keller National Center is listed below. The evaluation and training fees are substantially less than actual cost.

Schedule of Fees for Services Provided at the Helen Keller National Center Effective October 1, 1981

EVALUATION - (Ten weeks required to complete)	$100.00 per week
REHABILITATION TRAINING - Adjustment, prevocational, and/or job training (time required to complete determined by the needs of the individual)	$90.00 per week
MAINTENANCE - Room, board, essential laundry and related services	$90.00 per week
INCIDENTAL EXPENSES -	$8.00 to $10.00 per week

All Authorizations for services should be issued to the Helen Keller National Center for Deaf-Blind Youths and Adults, and addressed as follows:

HELEN KELLER NATIONAL CENTER
for Deaf-Blind Youths and Adults
111 Middle Neck Road
Sands Point, New York 11050

Attention: Accounting Manager

IX. COST OF TRAVEL

In order to minimize the disparity between the cost of transportation for clients whose permanent residences are at a considerable distance from the Helen Keller National Center and those who live close to the Center, the Helen Keller National Center will continue to meet the cost of transportation in excess of $100 for the round trip between the client's permanent residence and the Center. The referring counselors should discuss transportation costs and travel arrangements with the Helen Keller National Center Intake Coordinator.

X. TRAINEE RESIDENCE

Trainees reside at the Peter J. Salmon Hall on the campus of the Helen Keller National Center.

Dr. **Smithdas**. Mr. Chairman, it is a pleasure for me to be with you today and to be able to discuss the needs of the deaf-blind American citizen. Before 1967 here in the United States there was only one local program that gave training to deaf-blind men and women. In the rest of the United States there was practically nothing in the way of supplying deaf-blind people with training, with the kind of jobs that would make them independent citizens. In 1969, Dr. Peter J. Salmon was then executive director of the Industrial Home for the Blind, and I approached him for the establishment of a national center for deaf-blind citizens, because we knew that there was a lack of educational rehabilitation facilities as well as facilities to help them to know how to deal with the problems of deaf-blind people. We also knew that our program for the blind was the only one that was really giving service to deaf-blind persons.

Congress passed the establishment of the National Center for Deaf-Blind unanimously. In 1969 we began a program of services in a temporary facility. We operated with a staff of 25 persons taking deaf-blind clients. Then about 7 years ago we moved into our permanent facility, where we have between 25 and 52 clients at a given time. I would like to say that deaf-blindness is probably one of the severest disabilities known to mankind. When both sight and hearing are severely limited, the world literally shrinks and becomes only as large as he can reach with his fingertips or by using his senses of taste, touch, and smell. Yet over the past 13 years we have been able to have the center and deaf-blind people can be trained, they can be placed in jobs where they can earn their own living.

My wife, who is also deaf-blind, was in permanent training at the Helen Keller Center. She is now employed as an assistant instructor in communication and teaches other deaf-blind clients.

We feel that we have accomplished a great deal in our program. At least two of our former clients are now consultants in their home States; one former client is a rehabilitation counselor; one is director of an educational program in a college for the deaf; one is an assistant instructor in communications; and two are computer programers. Seven former clients are now employed as paraprofessional aides in schools and special centers; two are certified teachers working with deaf-blind children.

Several are employed in the electronics industry, including two at Hewlett-Packard, one at International Business Machines. Others are employed in furniture factories. One is employed in a lumberyard, and there are several who are employed in hospitals where they work in supply rooms or laundries. One of our former clients has been out for 10 years, and works in a factory in Illinois. Another outstanding client has been employed for several years by the U.S. Navy, and 2 years ago when the Navy's outstanding worker of the year award was given, he won that award.

When deaf-blind people come to us they seem to be almost untrainable because they have been neglected, never given the chance to express themselves as human beings. But we have brought many of these up to the level where they can work in programs and contribute to the life of their communities. In my own case, I have been employed for many years in public relations. At the present time, 20 percent of my paycheck goes to taxes. My wife also contributes to taxes. The point I am trying to bring out is that if these deaf-blind people are thrown to the mercy of the States they would probably be neglected as they have been in the past. One-to-one training must be used to teach them how to communicate, teach mobility, and independent living.

If these same persons were to be isolated again, it would mean that they would possibly become like wards of the various States. They would be lost in the shuffle of various groups of the handicapped who can express themselves far better, because the deaf-blind have little or no speech.

Many of the deaf-blind clients who have left us at the Helen Keller National Center have gone on to make their own livelihoods and pay their own taxes. It is expensive, but it is far better than it would be if you maintained them for the rest of their lives as public wards.

I would also like to say that on behalf of the National Center, we have developed a radio for deaf-blind persons, a quality communicator. It is a small transformer which has five jacks on the front, each jack with a different signal. The deaf-blind home person who lives in an apartment has a small pocket receiver. With this, if the doorbell rings, he is aware of the signal. He also knows when the telephone rings or when he is being called by a deaf or deaf-blind spouse or roommate. This device has also been widely accepted by the deaf, who usually use flashing lights, which require a great deal of electricity.

Most importantly, I feel that it would be a calamity if the Helen Keller Center were not funded directly by the U.S. Government. They are truly one of the most needy groups, and their needs are very special. They are also human beings who have the same desires and cravings as other people. They want to be recognized. They want to have freedom, they want to do the same things that I have noticed other people are doing.

Mr. ADLER. Thank you.

[The prepared statement of Robert J. Smithdas follows:]

PREPARED STATEMENT OF ROBERT J. SMITHDAS, L.H.D., LITT.D., L.H.D., DIRECTOR OF COMMUNITY EDUCATION, HELEN KELLER NATIONAL CENTER FOR DEAF-BLIND YOUTHS AND ADULTS, SANDS POINT, N.Y.

Mr. Chairman, and Members of the Subcommittee: In 1967, the late Dr. Peter J. Salmon, executive vice-president of The Industrial Home for the Blind, Brooklyn, New York, and I testified before Congress for the establishment of a national center for deaf-blind youths and adults. We knew that there were thousands of American citizens who, deprived of both sight and hearing, were not being given rehabilitation and training that would enable them to overcome the dual handicap of deafness and blindness and provide them with the skills to realize a greater measure of self-sufficiency and independence. Many of these citizens were living lonely, isolated and neglected lives, and many were institutionalized because there was a lack of professional workers who knew how to communicate with them and provide the assistance they needed.

There is no doubt that deaf-blindness is one of the severest handicaps known to mankind. When both sight and hearings are severely limited or totally absent, the world shrinks for the individual, and becomes only as large as he can reach with his fingertips. Deaf-blind people require intensive training on a one-to-one basis in order to become functioning productive citizens who can contribute to the life of their communities.

It is commendable that Congress understood the urgent needs of deaf-blind Americans and unanimously passed legislation for the establishment of a national center, now known as the Helen Keller National Center for Deaf-Blind Youths and Adults, in 1969. In the thirteen years of its existence, the Helen Keller National Center has trained hundreds of deaf-blind men and women from all parts of the United States and its territories, and provided an expanding program of direct services to assist with their special needs. As chairman of the Committee on Services to the Deaf-Blind of the World Council for the Welfare of the Blind of the United Nations, I am proud to state that the Helen Keller National Center has won world-wide acclaim as an outstanding and unique agency.

Many of the Center's former clients have gone on to successful careers as professional workers, proving that the handicap of deaf-blindness can be overcome when proper training is provided. Two former clients are consultants in their home states; one former client is a rehabilitation counselor; one is director of an educational program in a college for the deaf; one is an assistant instructor in communications; and two are computer programmers. Seven former clients are now employed as paraprofessional aides in schools and special centers; two others are certified teachers working with deaf-blind children. Others are employed as workers in electronics plants, furniture factories, and other competitive jobs. One client, employed by the United States Navy, was selected as its Outstanding Federal Handicapped Employee of 1980. Several have completed junior college, and at least two have obtained Master's degrees. There are many others who are either self-employed or employed in competitive industry. Many others work in sheltered workshops. We are proud of the record of the Center's graduates and their accomplishments, and the knowledge that they are now self-supporting and no longer a burden to other taxpayers.

One example of the many employed deaf-blind concerns a profoundly deaf man who lost his sight in his late thirties. Unable to obtain services in his home state, where professional workers were unfamiliar with the unique problems of deaf-blindness, he arrived at the Center with poor communication and mobility skills, but with a strong desire to work and be self-supporting. After completion of his training, the Center's placement specialist found a job for him at Barber-Coleman Company in Illinois as a hydraulic press operator. He is still employed by the company, and is justly proud of his ability to support himself and his family. Despite the fact that he is totally deaf and totally blind, and lacks understandable speech, he travels to and from his place of work daily, using local transportation.

It is imperative to realize that the success of most deaf-blind American citizens depends wholly on the continued support of the Helen Keller National Center by the United States Congress. We ask that your committee pass legislation establishing a direct line of funding for the Helen Keller National Center so that it can continue to provide a program of services that is urgently needed, and one which cannot be provided by any single state. The Helen Keller National Center's program of services is not a giveaway; it is not a handout. It is intended to provide deaf-blind citizens with the skills which will give them a greater measure of freedom, and the dignity of knowing that they are human beings who can contribute productively to their country.

Mr. MURPHY. Thank you very much, gentlemen.

As a personal note, where did the doctor learn to speak so well?

Dr. SMITHDAS. I lost my hearing and sight when I was 4½. By the time I was 16 I was not understandable even by my own family. I would not pronounce new words that I read in books because I was afraid of the other students at school making fun of me. I went to a school for the blind when I was 16, where they had a big department for deaf-blind children. They taught movements of the lips, tongue, and movements of the breath in making different sounds. It was an extremely hard thing to learn, I admit, but I think that it has been a bonus for me.

Mr. MURPHY. Tell him we understood every word, and I thought it was an excellent presentation.

Dr. SMITHDAS. Thank you very much. I would like to say that when I was being brought up as a student in special schools and then employed, we did not have a rehabilitation program for deaf-blind people. It has only been in the last 20 years that anything has really been done in the way of services for the deaf-blind. That means that I was one of the very fortunate ones. But there are thousands of others who have not been as fortunate, and I do feel that I have an obligation that since I have had such success, others who are less fortunate should have the same right.

Mr. ADLER. I might add if I may that Dr. Smithdas has needed almost 200 volunteers over a period of time to work with him while he went through school. That is because there were no established systems in operation at that time.

Mr. MURPHY. Mr. Erdahl?

Mr. ERDAHL. Thank you very much, Mr. Chairman. Before I have some comments or questions of our panelists, I would like to again repeat the welcome that I made at our hearing in St. Paul, to welcome you and Mrs. Murphy to Minnesota and to this hearing and this lovely setting at the Vinland Center and to welcome the others here as visitors and guests and those taking part in the testimony in the hearing this afternoon.

Just a couple of questions, and I will maybe address this first to Dr. Smithdas. Dr. Smithdas, I think you mentioned what we would call maybe a breakthrough in electronics and in the new devices and what not that aid people who have various handicaps, and it seems to me that we are just on the threshold of some exciting new frontiers in this area, and maybe you could elaborate a bit on what you see ahead.

Dr. SMITHDAS. I feel that any effort to communicate is a breakthrough. When the telephone rings, we already have an electronic teletype machine which can be coupled to the telephone receiver. My wife and I have one at home so when the telephone rings and we receive the telephone signal, we pick up the receiver and place it in the catheter and we can communicate with deaf-blind friends or others who have TTY machines. We communicate with our family and friends in Hawaii and Texas. If we did not have that we would be able to have a machine to print into braille. In fact, there already is one in West Germany, though I have not yet seen it.

Another important device is a device that would make it easier for a deaf-blind person to cross the street by himself without the attendance of other people, but this may be some distance in the future. We also have a new magnetic tape telephone device that is being developed in California which may do away with the paper tape, and the size of the TTY machines.

Mr. ERDAHL. Thank you very much, Dr. Smithdas.

Now I have a couple of questions for you, Mr. Adler. First of all, I think you put your finger on what I think is the proper emphasis for this bill, and I am joining with my colleague from that area, Mr. LeBoutillier, to try to give some permanence and assurance that down the road we will have an ongoing authorization. I think that should be part of our commitment as a nation across party lines and across elections that come and go, so that you can have that assurance.

I would like to ask a couple of questions. One would be how many people have been served at the Helen Keller Center since it was formed? Another question, if I could ask a couple at the same time, is there a waiting list, and what might be the ages of the people that are served? I will let either one of you field those questions.

Mr. ADLER. I would like to answer them. We have served at the center itself at headquarters—again we can only work with about

45 to 52 at any one time, and the center has been in operation in the new place since 1976. Before we were working with about 20 clients at any one time. The total number, however, since 1969, is 360 something at headquarters. In the field, however, we work with an average of 600 to 700 clients in direct services. We have nine regional representatives who provide direct services to clients throughout their geographical area. In addition, what we have established very, very recently is a national network affiliation service of some 22 agencies around the country.

For example, the Minneapolis Society for the Blind was one of our earliest affiliated agencies, where these agencies work as part of our funding. We have frequently trained their staff to work with the deaf-blind, and they in turn work with the local deaf-blind individuals. Thus we are trying to fulfill the concept of a nationwide service spread out across the Nation with relationships between the different service delivery systems. This is why we call it a network system. So that basically as a result of the moneys received, some $21 million total with HKNC, several thousand deaf-blind people have had impact from our services, some 360 something directly at HKNC, which means that they stay from 10 weeks to a length of 4 to 5 years, or from our direct service representatives in the field or from our affiliated network system.

Did that answer the question, sir?

Mr. **Erdahl**. Yes.

Mr. Chairman, the other one I had would be the ages.

Do you serve children at a very young age?

Mr. **Adler**. During the summer program we accept children between the ages of 16 and 18 because we know that they will soon be coming to HKNC, and we are preparing them for the work there. Our system works 12 months a year. During the rest of the time we work with blind from the ages of 18 to 60, 65.

Mr. **Erdahl**. Why not the very small child?

Mr. **Adler**. That is worked with by the deaf-blind regional centers for deaf-blind persons. They work with the children there. When the children are ready to leave the systems there, they come to us. For example, the rubella bubble, we are now going to get many of the rubella children who are now young adults. We are expecting some 6,000 deaf-blind rubella people, 6,000. In fact, 6,064.

Mr. **Erdahl**. Mr. Adler and Dr. Smithdas, I want to thank both of you for being with us, for coming here to Minnesota, and the eloquence of your testimony and your presence is an inspiration to all of us. Thank you.

Mr. **Adler**. We thank you, sir.

Mr. **Murphy**. Thank you very much, gentlemen. I will have written questions for you, and also our colleague Mario Biaggi has asked me to come there and take a tour, so I may be doing that one of these days.

Mr. **Adler**. People from all over the world come, and they are expecting something mild and they leave with their jaws wide open. Please come.

Mr. **Murphy**. Thank you very much.

The next panel of witnesses, representing the Vinland National Center are the Honorable James C. Swanson, a member of the

Minnesota House of Representatives, Dr. Tor Dahl, Mr. Philip Carpenter, and Dr. Keith Vanden Brink.

Mr. ERDAHL. Maybe while they are getting seated, with your permission, I will mention again for the record that I have received numerous personal letters, one from the director, Gerald Nesset [phonetic] giving words of support for the endeavor here. Another from Mr. Swanson's colleague in the House of Representatives, State Representative Janet Clark, also a very supportive statement. Rather than take the time to read those, I will submit them after I have made a personal response to the letters, and I trust they can be made a part of the record, Mr. Chairman.

Mr. MURPHY. They will be, without objection.

[The information referred to follows:]

CAMP IHDUHAPI

A BRANCH OF THE METROPOLITAN MINNEAPOLIS YMCA

LAKE INDEPENDENCE • LORETTO, MINNESOTA 55357 • (612) 479-1146

• (612) 479-1966

August 25, 1982

Honorable Arlan Erdahl
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Erdahl:

I am writing in support of the Vinland National Center program. I have seen the program in action, visited with participants - handicap and student interns - and feel the program is highly professional and productive.

Our YMCA Camp Ihduhapi motto is "to bear your own burden". This we paraphrase for campers as "learning to be independent, or to take care of yourself". The Vinland program helps handicap adults do this very well.

I see a great value in human, and economic, terms for our American society through this program. Persons better able to care for themselves, feed themselves and become more probably employable because of enhanced health and fitness. These will be contributing members of society, not a burden.

I see the Vinland program providing a value plus in its approach to health enhancement, lifestyle education, sports and nutrition education. I heartily encourage your thorough consideration of this program for the societal benefits and as being very worthy of funding.

Sincerely,

Jerold Neseth
Executive Director

JTN/ck

A summer camp for youth plus a year 'round conference site dedicated to developing Christian personality since 1930

Janet Clark
District 60A
Hennepin County
Committees:
Criminal Justice
Education
Energy
Health and Welfare

Minnesota House of Representatives
Harry A. Sieben, Jr., Speaker

September 1, 1982

Congressman Arlen Erdahl
1518 Longworth Office Building
Washington, D. C. 20515

Dear Congressman Erdahl:

On September 2, 1982, a Congressional Hearing has been scheduled to review the progress and plans of the VNC, a national healthsports center established by the Bicentennial gift to the U.S.A. from the Kingdom of Norway. There are four important aspects of the VNC I would like to share with you.

1. The national scope of the Vinland National Center provides a much needed national resource to local and regional rehabilitation organizations interested in providing healthsports/recreation services as part of the rehabilitation process. As a national resource, Vinland seeks to meet the needs of collecting information currently available, documenting the state of the art, preparing materials for dissemination and training disabled persons and professionals in the field of healthsports thereby reducing the occurence of "re-inventing the wheel" as is so often done by local recreation/rehabilitation programs due to lack of available printed materials, trained staff, equipment adaptions or accessible facilities. By encouraging its graduates to participate in local/regional programs, Vinland helps to maximize the utilization of existing local resources and is complementing current rehabilitation and recreation programs.

2. The VNC is also addressing the need to adequately train and inform health-care, recreation, rehabilitation and education professionals at the local/regional level in order that they can provide the necessary support to disabled persons in implementing a physical fitness program, recreation and positive health habits into their lifestyles. Vinland is providing a national communications network so that new trends, updated information on recreation, sports and equipment adaptions reach local communities on a timely basis. In addition, Vinland is working with Boston University to develop a master level degree program in healthsports and is cooperating with many other colleges and universities to provide an internship program for their students in order that newly trained professional will return to their communities prepared to conduct healthsports programs.

Reply to: ☐ 291 State Office Building, St. Paul, Minnesota 55155 (612) 296-4354
☐ 3439 11th Ave. So., Minneapolis, Minnesota 55407 (612) 724-5605

3. The programs offered by Vinland will specifically assist three types of disabled American citizens who can benefit from this unique and innovative approach in rehabilitation. First, are those persons who have been recently disabled. During the initial rehabilitation period, very little time is available for the development of social and physical skills which are necessary for an effective transition to the mainstream of society. Through healthsports, a disabled individual can examine their options with regards to his/her new physical, social and emotional lives, arrange and test these new options to effect a successful transition into the able bodied world.

   Second, are the persons who have been disabled for a long period of time, live a sedentary lifestyle and are unemployed. In a recent study conducted in California, the researchers found that the main reason for disabled persons to be chronically unemployed is due to their inability to relate to able bodied coworkers, not their inability to perform the job nor their inability to get to work. The healthsports concept is aimed at providing the social and recreational skills necessary for disabled persons to work and recreate with able bodied coworkers, friends and family.

   Third, are those persons disabled by war related injuries. These persons can obviously benefit from the above mentioned physical, social and vocational benefits but also, perhaps more importantly, is the impact of healthsports upon the emotional health of a disabled war veteran. A disabling injury, especially if related to violence, leaves an emotional scar that is often more handicapping than the physical impairment. Healthsports activities are designed to restore self-confidence, an improved self-concept and promote an attitude of "If I can do this, then I can do anything". Healthsports should never be viewed only as fun and games, but rather viewd by its total impact on the vocational, physical, social and emotional health of a disabled persons.

4. The International scope fo the VNC began with its inception, a gift from the country of Norway. An International collaboration has grown and strengthened in the recent years through staff exchange programs between Vinland and the Beitostølen Helsesportsenter, planned joint publication of training materials and research projects, and international sporting events. This International cooperation is not limited to just Norway and the U.S., but also includes many other industrialized and developing countries. Canada is now in the developmental stages of establishing its healthsports center in British Columbia. Japan invited Beitostølen to bring the healthsports concept to Japan for a demonstration. Kuwait attended its first healthsports event this year, and is now planning its own center. The Norwegian Ridder Renn hosts 17 countries annually for a week of skiing and a 23K race. Vinland was asked to present at a conference on Water Activites for Disabled Persons in England during 1981, the International Year of Disabled Persons. Healthsports training as part of the rehabilitation process is growing and the VNC has the potential to provide leadership and support, similar to what Norway has done for the U.S. to other countries as they incorporate this new concept into their rehabilitation systems for disabled.

It is an exciting time for the Healthsports concept. The years of planning and nurturing of the American National Center for Healthsports - the Vinland National Center - has now become a reality. Your attention to this most important project will help dramatize and insure its success.

Sincerely,

Janet Clark

Janet Clark
State Representative

JC/bz

PASS

E.O. 12356: N/A
TAGS: SCUL, NO
SUBJ: VINLAND NATIONAL CENTER

TO: CONGRESSMAN ARLEN ERDAHL
U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, D. C. 20515

AS AN IMPORTANT PART OF AMERICAS BICENTENNIAL, HIS MAJESTY KING OLAV V, ON BEHALF OF THE PEOPLE OF THE KINGDOM OF NORWAY, GENEROUSLY GAVE A QUARTER OF A MILLION DOLLARS TO THE VINLAND CENTER IN MINNESOTA.
THIS UNIQUE CENTER IS A SUPERB EFFORT TO AID AMERICAS AND EVENTUALLY THE WORLDS HANDICAPPED. THEY ADDRESS TRAINING AND INFORMING THE HANDICAPPED IN HEALTH CARE+ RECREATION+ REHABILITATION AND EDUCATION. TO PUT IT SUCCINCTLY+ THEY TEACH AND INSPIRE THE HANDICAPPED THAT THEY HAVE A CONTRIBUTION TO MAKE TO SOCIETY. THEY DISCOVER ALL PEOPLE ARE MORE OR LESS HANDICAPPED IN ONE WAY OR ANOTHER. THEIRS MAY BE BLINDNESS OR MISSING LIMBS — SO WHAT? SAY THEY. LETS GET ON WITH THE BUSINESS OF LIVING AND HELPING OTHERS. THEY TRAIN THE HANDICAPPED TO RETURN TO THEIR OWN COUNTRIES AND PASS ON THE PHILOSOPHY, KNOWLEDGE AND ATTITUDE TO SIMILARLY AFFLICTED PEOPLE

NORWAY HAS A SIMILAR BUT FAR MORE ADVANCED CENTER CALLED BEITOSTO THAT HAS BEEN UNBELIEVABLY SUCCESSFUL. THEY NOW INTERCHANGE WITH THEIR U.S. COUNTERPART+ VINLAND, FACILITIES AND FACULTIES.

LAST MARCH HIGH ON THE MOUNTAINS OF NORWAY, I PERSONALLY WITNESSED 800 SKIERS FROM MANY COUNTRIES SKIING OVER A 16 KM. COURSE. NEVER HAVE I SEEN MORE POSITIVE+ HAPPIER+ DETERMINED PEOPLE -- ENCOURAGING EACH OTHER. MOST WERE BLIND OR NEARLY SO. I SAW ONE MAN WITHOUT LEGS PUSH HIMSELF OVER 16 KM. IN A SMALL DISH-LIKE DEVICE. HAVE YOU EVER SEEN A WHEELCHAIR BALLET?

THEY HAVE LEARNED NOT TO FEEL SORRY FOR THEMSELVES+ BUT FOR OTHERS, WHO HAVE PROBLEMS FACING LIFE AND ITS CHALLENGES.

THIS IS THE STORY OF VINLAND (A NAME USED BY ANCIENT NORSEMEN WHO THOUGHT THEY HAD DISCOVERED GREENLAND INSTEAD OF AMERICA).

AS U.S. AMBASSADOR TO NORWAY, I HAVE SEEN THE VALUE OF THIS PROJECT. AS YOU MEET IN MINNESOTA ON SEPTEMBER ~~25~~ 2 FOR YOUR HEARING, I RESPECTFULLY OFFER MY STRONGEST SUPPORT FOR THIS WORTHY EFFORT. ITS POTENTIAL FOR INTERNATIONAL ANSWERS TO THESE INTERNATIONAL PROBLEMS MERITS YOUR AND MY STRONGEST CONCERNS.

SINCERELY,
MARK E. AUSTAD
AMBASSADOR

AUSTAD

JB

RECREATION EDUCAION X973
612 WEST SEASHORE HALL
IOWA CITY IA 52242

western union Mailgram

4-0397518236 08/24/82 ICS IPMBNGZ CSP WSHB
3193536808 MGM TDBN IOWA CITY IA 98 08-24 0330P EST

CONGRESSMAN ARLEN ERDAHL
US HOUSE OF REPRESENTATIVE
1518 LONGWORTH HOUSE OFFICE BLDG
WASHINGTON DC 20515

DEAR CONGRESSMAN ERDAHL
RE: PUBLIC HEARING ON HR 6820 THE HANDICAPPED INDIVIDUAL SERVICES TRAINING ACT. THE VINLAND NATIONAL CENTER PROVIDES CRITICALLY NEEDED NATIONAL LEADERSHIP IN COPING WITH MASSIVE FREE TIME OF DISABLED WHO ARE UNEMPLOYED, MARGINALLY EMPLOYED, OR RECREATIONALLY DISENFRANCHISED, ETC. THE VINLAND NATIONAL CENTER ALSO ADDRESSES CRITICAL NEED OF ALL DISABLED FOR HEALTHFUL LIVING COMPETENCY. I URGE ALL POSSIBLE FEDERAL AND NATIONAL SUPPORT FOR VINLAND NATIONAL CENTER.

JOHN A NESBITT, ED.D. PRESIDENT SPECIAL RECREATION INC 362 KOSER AVE
IOWA CITY IA 52240

15:27 EST

MGMCOMP

TO REPLY BY MAILGRAM, SEE REVERSE SIDE FOR WESTERN UNION'S TOLL - FREE PHONE NUMBERS

UNIVERSITY OF MINNESOTA
TWIN CITIES

Adolescent Health Program
D136 Mayo Memorial Building
Box 721 Mayo
420 Delaware Street S.E.
Minneapolis, Minnesota 55455
(612) 376-8413

Congressman Arlen Erdahl
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Erdahl:

I am writing this letter in support of HR6820, the Handicapped Individual Services Training Act. There are a number of aspects of this proposed bill which I find most exciting. Over the past four years we in the Adolescent Health Program at the University of Minnesota have been actively involved in working with youth with physical disabilities and chronic illness. We have run a program - Adventure, Etc. - for the past three years, and over the last year have worked most closely with the Vinland National Center in Loretto. The Vinland Center, we, and the Outward Bound School have collaborated in developing Adventure, Etc. for adolescents with chronic and terminal illness, and like many of the other programs in which Vinland has been involved, this represents an exciting demonstration model not available elsewhere in the country.

The proposed legislation would provide resources for developing innovative programs for those with handicapping conditions - certainly, a gravely underserviced population in America. I wholeheartedly support HR6820 and applaud your endorsement of it.

Sincerely yours,

Robert Wm. Blum, M.D., Ph.D.
Associate Professor and
Director, Adolescent Health Program

RWB:eb

August 23, 1982

Congressman Paul Simon
U.S. House of Representatives
Washington, D.C. 20515

Dear Congressman Simon:

I strongly believe that legislation introduced by Congressman Arlen Erdahl should have the support of all realistic and compassionate members of the United States Congress.

The Vinland Center has as its mission that of providing health and life-style education to Americans who need it the most: the millions of persons in the United States with disabilities. I feel that it should become fully operative as a national resource and I strongly urge you to support H.R. 6820.

Respectfully yours,

Charles F. Dayton
Box 756
Ely, MN 55731

cc: Congressman Arlen Erdahl

August [illegible], 1982

909 Maine Street
Vallejo, CA 94590

Congressman Arlen Erdahl
U.S. House of Representatives
Washington, D.C. 20515

Dear Congressman Erdahl;

I am writing in support of H.R. 6820, The Handicapped Individual Services Training Act.

Last December, I had the pleasure of observing ten handicapped individuals discover or rediscover that they, and not the weather or any other barrier, could govern their own lifestyle. Through a Vinland outreach program, held in New York, these people learned not only to sled ski, but that it was possible to maintain a healthful lifestyle year round. These ten people have taken on the Vinland philosophy and now share the healthsports concept with others. This is only one example of the impact that a national resource, such as the Vinland National Center, has on the handicapped population of this country.

While a student intern with the Vinland National Center, in the fall of 1981, I had many opportunities to observe the success of health and lifestyle education. In my present profession, as a Recreational Therapist with psychiatric patients and as an instructor for the Handicapped Skier's Association, I use the concepts taught by Vinland and find that these concepts are vital in the rehabilitation of people with disabilities.

In our country, freedom and equality are values that we continually strive towards. Freedom is often difficult for a handicapped person to experience as they must deal with barriers. At Vinland techniques are learned to enable the individual to work through these barriers toward freedom and equality.

It is now time for Vinland to become a national resource. The International and National Year of the Disabled Person have focused attention on a valuable segment of the population that has unfortunately been downtrodden and overlooked through the years. It is essential that the disabled citizens of this country have access to health and lifestyle education now; and this will only be acheived if the Vinland National Center receives your support.

Sincerely yours,

Kathi M. Fries R.T.

Kathi M. Fries

[illegible]

Sentry Insurance

Sentry Insurance
A Mutual Company
1800 North Point Drive
Stevens Point, WI 54481
715 346-7747

August 23, 1982

Congressman Arlen Erdahl
U.S. House of Representatives
Washington, D.C. 20515

Dear Congressman Erdahl:

I would like to submit some comments regarding Vinland National Center that may be submitted to the select congressional subcommittee meeting to be held at Vinland National Center on September 1, 1982.

I am a physician with a background in general family medicine having been in private practice beginning in 1962. I am presently Vice President & Medical Director at Sentry Insurance Company in Stevens Point, Wisconsin. My present responsibilities not only include standard medical consulting duties for the company but the overall supervision of the Employee Health Program. This program is a broad-based program which looks at possible health intervention at three times in a person's life. The classic intervention time, of course, for which most doctors and nurses are trained is when somebody is sick and, therefore, we do maintain a prompt, high-quality intervention service. In recent years it has become apparent that it is better for the person and for the cost of caring for a person's health if we intervene when people are relatively well with health evaluations, health education, screening programs, periodic examinations, etc. We do run all of these programs including extensive health education in the areas of nutrition, exercise, rest, stress management and the improvement of personal satisfaction and interpersonal relations at home and on the job. The third area that we emphasize and one I feel has heretofore received too little attention is the principal of intervening at the time in a person's health when they are neither well nor did they particularly recover or be cured from some illness or injury and they are left with a disability. We run an "Adaptive Program" with a great deal of individual attention to helping people with various disabilities achieve higher levels of wellness. This would include individuals with arthritis, cerebral palsy, multiple sclerosis or those who have suffered heart attacks, strokes, etc.

It was only recently that Vinland National Center came to my attention and as a person who is quite familiar with what is available nationally, it appears to me that this was one of the few sources in the country that did such a fine job with overall wellness for the handicapped. I have made several visits to Vinland to meet the staff and as a result of that felt it would be important to send a member of our own physical fitness staff for one of the three-week programs. I did this and have talked to our staff member since his return from the program. I can only say all of the hopes and expectations I had were fully met and I feel Vinland National Center has the potential for fulfilling a national resource need.

It appears to me that the ability and the willingness to succeed is already being conveyed to those people attending and I would strongly urge consideration for national funding to expand its influence and availability. I would be pleased to answer any further questions or be of any help that I can in furthering this endeavor.

Sincerely,

Donald D. Johnson, M.D.
Vice President & Medical Director

DDJkd

August 25, 1982

Congressman Arlen Erdahl
United States House of Representatives
Washington, D.C. 20515

Dear Congressman Erdahl,

I am writing to you to express my support for The Handicapped Individual Services Training Act, H.R. 6820. I have had some help writing this letter. It is my feelings about Vinland, but I had help with the words.

I have recently attended a three-week session at the Vinland National Center, and feel it was like a dream come true. Even before my experiences with a disability, I held dreams of a place for people to go and all feel equal, without feeling their differences. At Vinland, this was very real to me. The staff and visitors all seemed to be as one. In our visits to organizations, and in different activities, I felt truly independent, and not reliant on others. I was treated as an adult and allowed to make my own decisions.

National Centers such as Vinland can be of vital importance to people with any kind of disability. The feelings of self worth that are gained through this enable persons to become more aware of their abilities. On a national level, this type of program would promote awareness of the capabilities of persons with a disability.

This is a critical time in the development of centers such as Vinland. I appreciate and thank you for your support of H.R. 6820. Feelings are hard for me to express, but I hope this gives you an idea of how I really feel.

Sincerely,

Rick (Mc)
Richard McMullen
GRAND ISLAND, NEBRASKA

August 23, 1982

Rep.Arlen Erdahl
U.S. House of Representatives
Washington, D.C. 20515

Dear Rep. Erdahl:

I hope this letter numbers among many that you have received in support of bill # 6820, Handicapped Individuals and Services Training Act.

The money that this legislation would give to the Vinland National Center would promote the kind of programs that help individuals with disabilities develop the skills necessary for living. The current programs at Vinland are outstanding in their approach to health, quality living, self-advocacy, life involvement, personal responsibility, nutrition and wellness. These programs are rare in the United States yet they are the very backbone of a movement that acknowledges individuals with disabilities as having the right to those parts of living and life that those of us who are able-bodied are automatically given.

Vinland's national impact is evident by the demographic breakdown of participants in their past programs. I attended a program for 3 weeks in March of this year and participated in training for health with other individuals from all parts of the country. Funding for the Vinland center is crucial at this point in time. Programs of this nature need tremendous support and while Vinland has this support from its staff, its participants & many health professionals, financial support of this nature could allow for long range planning, continued staff training, the development of training manuals and allow many individuals the opportunity to experience life as they never have before.

That, in essence, is the importance of Vinland's programs. Because of their sophistication, individuals with all disabilities are given the opportunity to participate in opportunities that are quite frequently denied them due to societal barriers, attitudinal barriers, family fears, lack of experience and general misunderstanding about disability, and more importantly, ABILITY. Legislation of this nature is progressive, proactive and timely. Let's have Minnesota and Vinland lead the way in educating the rest of the country, in demonstrating acceptance of ALL individuals and in living up to our responsibility as human beings to provide ALL people with the opportunity to live active, fulfilling and satisfying lives.

Please know that many of us are counting on you and your committee to keep these programs alive, dynamic and growing and I pledge my support to the ideals of Vinland, hoping that this support is returned by the passage of this legislation.

Thanks for your attention to this letter.

Sincerely

[illegible]
[illegible] MINNEAPOLIS, MN

JAN NERI

Olav Pedersen
P.O. Box 131
Breckenridge, Colorado
80424

August 23, 1982

Congressman Arlen Erdahl
U. S. House of Representatives
Washington, D. C. 20515

Dear Sir:

It has come to my attention that you recently introduced legislation in Congress to enable Vinland National Center to fulfill its intended objectives to provide health and lifestyle education to millions of Americans with some disabilities.

I commend you for your initiative and will try briefly to give you a historic background for why I took the initiative to bring "Ski for Light " to the U. S.

The great success Erling Stordahl's program at Beitostolen Healthsport Center in Norway had proved that most handicapped persons, if given the opportunity, could greatly reduce their handicaps and turn into productive members of the society. This was in itself a great accomplishment and satisfaction, not at least for those directly involved. But perhaps the most eye opening aspect of the program was that it actually paid for itself, yes, one can even say the invested money gave more return than anybody had ever thought possible.

So, why shouldn't the millions of disabled persons in the U. S. be given this opportunity to prove themselves? I wanted an answer to that question, and in September 1973 I went to Norway and asked my long time friend, Erling Stordahl, to assist me in introducing his program here. Result: "Race for Light" in Summit County in February 1975. Govenor Richard Lamm was one of the pioneer guides for the blind participants and the local as well as the Norwegian support was overwhelming.

One year later, after "Ski for Light" in Minneapolis, H. H. Crown Prince Harold of Norway on July 2, presented President Ford with that country's Bicentennial gift, one million N. Kr., the money earmarked for a healthsport center in the U. S., modelled after the one at Beitostolen.

The meeting held at the White House that same day, seemed to indicate that the Norwegian initiative would be well received and accepted. It is now up to the legislative body to demonstrate that those who in some very unfortunate way have been treated and looked upon as an unproductive burden of society, should be given the opportunity to show how unfair that judgement was.

I strongly support your effort through H.R. 6820, The Handicapped Individual Services training Act!

Sincerely,

Olav Pedersen

Olav Pedersen

/am

Copies will also be sent to all the Congress representatives from Colorado. O.P.

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New Hope, Minnesota 55428
Phone: 535-6171

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ALICE TUSETH

ADMINISTRATOR
WAYNE H. LARSON

August 19, 1982

Congressman Arlen Erdahl
U. S. House of Representatives
Washington, D.C. 20515

Dear Congressman Erdahl:

I am writing to you to thank you for your initiative in introducing legislation which would earmark funds needed to complete the Vinland National Center in Minnesota. Although Twin Citians are fortunate to have ready access to health and sports related programs, many persons throughout the country are not provided easy access to such programs due to actual or perceived lack of opportunities. The Vinland National Center would provide a much needed model of service to enable persons with physical disabilities an opportunity to develop various health and sports related skills in a supportive environment. Graduates from the Vinland National Center's programs would take back to their home communities increased levels of self-awareness and confidence, prerequisites for successful integration into a highly competitive work and leisure oriented society.

As a practitioner in Therapeutic Recreation Services working with physically and multiply disabled adults and children, I have seen, first hand, the benefits persons receive from programs such as those proposed at the Vinland National Center. Not only can one observe an increase in the vitality and positive attitude of the involved persons, but, also, one can begin to perceive improvements in the health status of the community at large. Certainly a national resource such as the Vinland National Center can be justified both socially and economically!

Please continue your arduous efforts in support of H.R. 6820, The Handicapped Individual Services Training Act. The United States of America cannot afford to continue to "handicap" its disabled citizens!

Most sincerely,

M. Tipton Ray

M. Tipton Ray
Therapeutic Recreation Specialist

cc: Vinland National Center
ATTN: Jean M. Saari, Director of Operation

MTR:ma

EQUAL HOUSING OPPORTUNITY — EQUAL EMPLOYMENT OPPORTUNITY

GREEN MOUNTAIN COLLEGE
POULTNEY, VERMONT 05764
[illegible]

August 24, 1982

The Honorable James M. Jeffords
United States House of Representatives
1524 Longworth House Office Building
Washington, DC 20515

Dear Mr. Jeffords:

Please allow this letter to serve in direct support of proposed H.R. 6820 - Handicapped Individuals Services and Training Act. This vital piece of legislation would enable the Vinland National Center to continue to expand as the designated national resource for providing health and lifestyle education to potentially millions of disabled Americans.

Having visited the Vinland Center in October of 1981, I can attest to the value that a program of this nature can provide to the overall disabled population of our nation. The importance of maintaining a national center for resource dissemination, research, and individualized training is critical to the goal of accomplishing "equal opportunity" for all. The achievements already realized by the Vinland Center are a credit to the field of health and therapeutic recreation. However, continued support is necessary to insure that the Center maximizes its potential as a national clearinghouse for sport and health programs for the disabled.

As you have demonstrated in the past, I am confident that your committment to this special population and to services designed to assist the disabled will continue. I urge your support of H.R. 6820.

Thank you for your time and consideration.

Sincerely,

Bob Riley gsv

Bob Riley, President
Vermont Recreation and Park Association
Assistant Professor of Recreation

BR:gsv
cc: The Honorable Arlen Erdahl
Vinland National Center

BRADFORD WOODS

Indiana University Outdoor Education,
Recreation, and Camping Center
5040 State Road 67 North
Martinsville, Indiana 46151
(812) 537-0427 or (317) 342-2915

August 25, 1982

Congressman Arlen Erdahl
U. S. House of Representatives
Washington, D. C. 20515

Dear Mr. Erdahl:

I am writing you to applaud your efforts on behalf of the Vinland National Center in Loretto, Minnesota. Specifically, the legislation that you have introduced to financially support the completion of the Center, is commendable.

The need for a national facility and program such as that being promulgated by Vinland, is great. Physically and other health impaired individuals are in desperate need of physical fitness and health training. Just as we witness the growing phenomenon of poor use of leisure time by "able-bodied" Americans, this problem is perhaps more acute for disabled citizens, since there are fewer opportunities for them to engage in "health sports" activities. And just as there is a urgent need to educate and find "healthy" solutions for the poor non-work habits of able-bodied Americans, there is a similar need to provide a program/facility equipped to offer equal opportunity for disabled Americans.

As a current member of the National Recreation & Park Association's Board of Trustees, a past President of the National Therapeutic Recreation Society and a current administrator of a national model outdoor education/camping facility/program, I find the Vinland concept most intriguing and worthwhile.

Bradford Woods provides camping for the handicapped, school camping, outdoor education, environmental education, programs for the aging and aged, continuing education, short courses, conferences, retreats, staff development, consultation, research, and winter programs.

Bradford Woods is also the home of Camp James Whitcomb Riley, Camp Tulip Tree, Camp Tu-Wa-Ki, Camp Bradford, and the American Camping Association National Headquarters.

I urge you to continue your efforts on behalf of the Vinland National Center and encourage you to seek the support of your Congressional colleagues.

I would be delighted to be of further assistance if needed.

Sincerely,

Gary M. Robb
Board of Trustees, NRPA
Past President, NTRS
Director, Indiana University's
Outdoor Education Center
at Bradford Woods

/bj

August 25, 1982

Dear Congressman Erdahl,

It is my pleasure to send you this copy of my letters of support for The Vinland Center.

As a paraplegic, I participated in Ski for Light 1982 and was so thrilled by it. I am working as a medical intern at Loma Linda University in California. If there is any way as a physician I can help you to promote this, please let me know.

I am most interested in healthsports. Hopefully, I can attend Ski for Light 1983.

Sincerely,

Jayne Schiff, M.D.
10905 Rincon Street
Loma Linda, CA 92354

Enclosure

10905 Rincon Street
Loma Linda, Calif. 92354
August 25, 1982

Congressman George Miller
U.S. House of Representatives
Washington, D.C. 20515

Dear Congressman Miller;

I am wrinting you this letter to urge you to support H.R. 6820, The Handicapped Individual Services Training Act which is being introduced by Congressman Arlen Erdahl.

I am especially interested in your supporting the Vinland National Center, a center for health-sports for the disabled which is located in Minnesota. As a physician, I see Vinlad's role as being crucial to the millions of Americans who are disabled and are in great need of the sevices it provides. Their programs, which emphasize wellness, responsibility for your own health, good nutrition, and exercise are the key to providing the information which is so needed among the disabled as well as health professionals.

I have personally seen peoples lives change after having attended the Vinland programs. In 1982, where the focus of health care is shifting to preventative medicine, Vinlad's programs are most timely.

I urge you to support this bill which is coming up in the very near future.

Sincerely,

Jayne Schiff MD

Jayne Schiff, M.D.

cc; Congressman Arlen Erdahl
Sharon Limpert, Vinland National Center

Mayo Clinic Rochester, Minnesota 55905 Telephone 507 284-2511

Steven G. Scott, D.O.
Physical Medicine
and Rehabilitation

August 23, 1982

Congressman Arlen Erdahl
U.S. House of Representatives
Washington, D.C. 20515

RE: Vinland National Center

Dear Congressman Erdahl:

The Vinland National Center, a health and sports center for the handicapped, provides services for the disabled as no other center currently does in the United States. Currently, there are literally millions of people in the United States' population who are handicapped. This number is growing each day and will soon include a large proportion of the voting population. The Vinland National Center is unique in that it provides health and sport resources for those who are in greatest need. The present medical costs and needs of people who are disabled are astounding and will continue to increase in the future unless programs are developed to keep this large segment of population healthy.

The Vinland National Center is a step forward in providing the millions of handicapped people an education and experience in healthful living. Therefore, I am writing to you in support of legislation H.R. 6820, The Handicapped Individual Services Training Act.

Thank you for your time, and I am sure that you will act in good faith.

Sincerely,

Steven G. Scott, D.O.

Steven G. Scott, D.O.

SGS/lam

University of
Nebraska
Lincoln

Department of Speech Pathology and Audiology
Barkley Memorial Center
Room 202
42nd and Holdrege
Lincoln, NE 68583-0731
Accredited by American Speech and Hearing Association
by Education and Training Board

August 30, 1982

Congressman Arlen Erdahl
U. S. House of Representatives
Washington, D. C. 20515

Re: H.R. 6820

Dear Congressman Erdahl:

The staff of Vinland National Center has informed me of the opportunity to offer my support for H.R. 6820, The Handicapped Individual Services Training Act. It is my understanding that this Act would enable Vinland to become a national resource; I support this totally.

I am disabled as a result of facio-scapulo-humeral muscular dystrophy. I am employed as a clinical instructor in speech pathology here at the University of Nebraska-Lincoln and am actively involved in church and community affairs in Lincoln. I attended a three-week session at Vinland in May, 1982, primarily to learn beginning swimming skills and to develop an appropriate exercise program; I accomplished these objectives and, in so doing, learned an enjoyment of sports and physical activity I had never before experienced. Although simply learning these activities was important to me, Vinland has more to offer than expert instruction in physical activities and recreation. . .

The Vinland staff members are very competent as professionals and are exceptionally caring and sensitive as fellow human beings. They created a wonderful spirit of community and teamwork in which everyone worked together to give or to receive help to accomplish personal and group goals. It seemed that the context of physical activities -- which are at the same time "work" and "play" -- provided the ideal situation for establishing such a community. This experience helped me catch the vision of how the disabled and nondisabled can work together interdependently in all aspects of work and play -- a vision that needs to become reality if we are to use our human resources optimally.

As a professional who works with communicatively disabled persons, I could also see the enormous value of experiences like those at Vinland. Usually, the most difficult aspect of treatment is to establish the use of new behaviors in the context of everyday living; behaviors may be performed well in the treatment room or the rehabilitation center, but the individual does not use them appropriately at home or at work. By having people live at Vinland for a period of time, new skills can be practiced at all times during the day. In this way, newly learned behaviors can be established in a person's daily routine.

As a muscular dystrophy patient, I have consulted with physicians, physical therapists, and medical social workers. As a speech pathologist, I have worked with all members of the rehabilitation team. Many of these people have been exceptionally knowledgeable, dedicated professionals. However, Vinland is the only place I have observed a community of the disabled and nondisabled persons working together and helping each other in such a mutually supportive, productive way. In addition, in my experience, its program is a leader in how to incorporate behavior changes into everyday life. Its emphasis on setting personal goals -- and doing the best at what you are still able to do -- is a breath of fresh air compared to the medical model's emphasis on what is "wrong."

In these important ways, Vinland is a model for those who wish to create maximally helpful programs for the disabled. Not only does Vinland espouse an optimistic approach to these programs, but the staff makes the approach become reality. For these reasons, Vinland should become a National Center.

Sincerely,

Lou Tomes

Lou Tomes, M.A., CCC-Sp

LT/as

Mayo Clinic Rochester, Minnesota 55901 Telephone 507 284-2511

*Physical Medicine
and Rehabilitation*

August 19, 1982

Congressman Arlen Erdahl
U.S. House of Representatives
Washington, D.C. 20515

Dear Congressman Erdahl:

I am writing in reference to H.R. 6820, The Handicapped Individual Services Training Act.

In particularly I am writing concerning Vinland National Center. As a Rehabilitation professional I am acutely aware of how important it is to integrate individuals who have suffered a disability back into society. Often times it is a long hard road of adjustment both personally and socially.

I have had an opportunity to visit Vinland National Center and see first hand what they are doing to enhance the lives of many of the disabled participants they serve. The staff are dedicated and are top notch in their respective fields. I did note, however, that their facilities are less than adequate to carry out the programs that they are now doing.

I believe that Vinland Center can and will have a national impact upon the lives of the disabled of this nation, providing them with experiential opportunities that will have long-term effects regarding their overall quality of life.

With this, I strongly support H.R. 6820 and urge its adoption into law.

Thank you Congressman Erdahl for all your previous and present support on behalf of the handicapped citizens of Minnesota and the United States. We support you and believe in you.

Sincerely yours,

Glen W White
Glen W. White,

GWW/ma

unh
UNIVERSITY OF NEW HAMPSHIRE
DURHAM, NEW HAMPSHIRE 03824

School of Health Studies
Recreation and Parks
227 Hewitt Hall
(603) 862-2391

August 20, 1982

Congressman Arlen Erdahl
U.S. House of Representatives
Washington, D.C. 20515

Dear Congressman Erdahl,

I'm writing in support of H.R. 6820, The Handicapped Individual Services Training Act. The Vinland National Center, which this legislation would support, has been a valuable resource to our program here at the University of New Hampshire. We have utilized many of the Vinland training manuals and adopted Vinland's philosophy of health and lifestyle education. A number of other programs in New England have also utilized Vinland as a resource.

Continuation and expansion of Vinland's program can only mean greater opportunities for individuals with disabilities. Opportunities which lead to fuller, more productive lives.

Congratulations for introducing this bill and best wishes toward seeing it become law.

Sincerely,

Jeffrey P. Witman

Jeffrey P. Witman
Planning & Training Specialist
Recreation and Parks Program
University of New Hampshire
227 Hewitt Hall
Durham, NH 03824

NORTH TEXAS STATE UNIVERSITY
P.O. Box 13857
Denton, Texas 76203-3857

RECREATION AND LEISURE STUDIES

August 20, 1982

Congressman Arlen Erdahl
U.S. House of Representatives
Washington, D.C. 20515

Dear Congressman Erdahl:

I am writing in support of funding H.R. 6820, The Handicapped Individual Services Training Act. In particular, I am in favor of that portion which provides funds for Vinland National Center. As an advocate, educator, researcher, and friend for the handicapped individuals for the past twenty years, I feel that establishing a firm financial commitment for Vinland is of the utmost importance. Sports and positive presentative health experiences for the handicapped have been too often overlooked in rehabilitative planning. Because of the spin-offs in terms of increased productivity and other social benefits, the Vinland concept is actually an inexpensive way of achieving natural goals of self-sufficiency, productivity and independence.

Please continue your efforts to support this bill.

Sincerely,

Peter A Witt

Peter A. Witt, Ph.D.
Division Chairperson and
Associate Professor

ns

cc: Dale Abell

COLLEGE OF EDUCATION • AC 817-565-2544

Medical Center

10701 East Boulevard
Cleveland, OH 44106

Veterans
Administration

August 20, 1982

Congressman Arlen Erdahl
U. S. House of Representatives
Washington, D.C. 20515

Dear Congressman Erdahl:

In my work at this Veterans Administration Medical Center, I have had the opportunity to learn about the available facilities at the Vinland National Center. I have been very much impressed by the programs that are offered there. They will be open to our patients representing another extremely valuable source of help in rehabilitation of veterans.

I urge you to support H.R. 6820, The Handicapped Individual Services Training Act, to the fullest extent possible. If there is any way in which I can help assure the passage of this measure, please advise me.

Thank you for your interest.

Sincerely,

R. WOLPAW, M.D.
Assistant Chief, Rehabilitation Medicine Service
Assistant Chief of Staff

CITY OF WORCESTER, MASSACHUSETTS 01608-1890
OFFICE OF THE
PARKS AND RECREATION COMMISSION

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SUPV. MAINTENANCE
JOHN W. LEARY
GEN. FORESTRY FOREMAN
PAUL X. TIVNAN
RECREATION SUPV.

August 17, 1982

Congressman Arlen Erdahl
U.S. House of Representatives
Washington, D.C. 20515

Dear Congressman Erdahl

I am writing to express strong support for H.R. 6820, The Handicapped Individual Services Training Act. I am well aware that this legislation would help make the Vinland National Center fully operational as a national resource and am strongly in favor of this

All Americans, especially those with disabilities, need health and lifestyle educational opportunities and we are behind other countries in providing these. Too often rehabilitation programs have emphasized the medical, educational, and vocational aspects of the restoration process while leaving social/recreational needs to chance. For a disabled person to fully reach his/her potential, all of these aspects must be developed.

Last spring I participated in a 3-week pilot program sponsored by Vinland. It was a very rewarding experience both professionally and personally. I not only learned many things to enrich the programs for disabled persons, but, as a severely disabled person myself, I also learned about my own capabilities.

I sincerely hope H.R. 6820 will be passed.

Respectfully yours,

Dwight Woodworth, Jr., CRT
Leisure Services Coordinator
for the Handicapped

Approved by;

Paul X. Tivnan
Recreation Supervisor

Congressman Joseph D. Early
3rd District, Massachusetts

CC: Thomas W. Taylor
Commissioner

"Pride in Our Parks"

BEST COPY AVAILABLE

Mr. MURPHY. Representative Swanson.

STATEMENT OF HON. JAMES C. SWANSON, A STATE REPRESENTATIVE FROM THE STATE OF MINNESOTA

Mr. SWANSON. Mr. Chairman and Congressman Erdahl, I appreciate the opportunity to be here. I am Jim Swanson, a State representative from the Richfield-Bloomington area. Since 1973 I have served as chairman of the Minnesota House Health and Welfare Committee. I thank you for the opportunity to be here today and to lend my support to H.R. 6820.

First I would like to cite some history on the Vinland Center in Minnesota. In 1976 Minnesota was presented with a unique proposal. As a bicentennial gift, the country of Norway presented $200,000 to the State. This money, if it were matched by a State appropriation, was earmarked to create a Minnesota health resource, education, and training center for the handicapped to be patterned after Norway's Bietostölen Health Sports Center. This was a totally new concept in care for the handicapped, centering on healthsports training.

My interest in this concept was threefold. First and foremost, as chairman of the health and welfare committee, I felt that this new approach to health care for the handicapped was a concept whose time had arrived. It concentrated on the philosophy that individual responsibility is the key to a healthy lifestyle: it stressed health promotion, rather than sickness treatment, for the handicapped. Minnesota continues this tradition today in the Governor's Council on Health Promotion and Wellness. Second, I was interested in this concept from a vocational standpoint, in my role I say in real life as an educator in the vocational system. And last, my Scandinavian heritage told me that this would be an excellent concept to bring to this Scandinavian State. I visited Norway last summer, and I still concur.

Consequently, I carried the legislation in the Minnesota House to provide a matching appropriation of State funds to create Vinland. House file 917 in 1977 appropriated $200,000. At the time of the legislative hearings, testimony was presented concerning the uniqueness of the Vinland concept, the lack of similar institutions in the United States, the established research basis for the concept, and the potential for reducing health care costs. Through a comprehensive program involving rehabilitation, health education, and health care research, the Vinland National Center would improve the social, mental, and physical health of handicapped people from Minnesota and from throughout the United States, and it would be not in competition with other facilities, but would be an extension beyond what was presently being done in any facilities, especially here in Minnesota.

We were able to steer this legislation through the legislature in 1977, when a State budget surplus still existed. Legislators and others interested in health issues awaited the construction of the center and the proof positive that this type of concept could indeed work. I am sure you will be hearing of that proof this afternoon.

There continues to be evidence that healthsports training, when combined with traditional rehabilitation and special education, significantly increases the chances of disabled persons to overcome the effects of their disabilities. The skills and confidence gained by disabled people as a result of healthsports training directly contributes toward improved normal social integration. We now are able to hear from Vinland participants that this concept has worked.

As a long-time supporter of Vinland, I would urge that H.R. 6820 be passed. The method of Federal funding seems an appropriate response to the need for Vinland Center. The decreasing Federal funding with the increasing percentage matching formula appears to be a good formula. These matching funds would peak in fiscal year 1985 at approximately $412,000, with a low of just over $130,000 in fiscal year 1986. I would strongly urge that an effort continue to be made to supply the funds through the private sector, as has been done since 1977. With the present fiscal constraints on both State and Federal budgets, we must look to the private sector to fill gaps left by cutbacks. We appreciate the Federal support, and will continue to support private efforts to fund Vinland. The roughly constant level of matching required by this legislation, ranging between $130,000 and $410,000 over a 5-year period, should be an achievable goal in the private sector.

Again, I appreciate this opportunity to speak to you on the importance of Vinland, and to convey my continued full support of this center, as well as my colleagues'. As I said in 1977 when I first proposed the Vinland bill, the Vinland Center is a model for the lifestyle enhancement of all Americans; its impact upon life quality extends far beyond the handicapped to the entire population. Passage of this legislation will again demonstrate that Minnesota's quality of life is second to none.

Thank you for coming to Minnesota with your committee, and I will be happy to answer questions, and I am aware there might be some that I can directly answer.

Mr. MURPHY. Thank you very much, Representative Swanson.

[The prepared statement of James C. Swanson follows:]

PREPARED STATEMENT OF HON. JAMES C. SWANSON, HOUSE OF REPRESENTATIVES, DISTRICT 37B, STATE OF MINNESOTA

Mr. Chairman and members of the subcommittee. My name is James Swanson, and I am a State representative from the Richfield/Bloomington area. Since 1973 I have served as chairman of the Minnesota House Health and Welfare Committee. I thank you for the opportunity to appear today to lend my support to H.R. 6820. First, I would like to cite some history on Vinland Center in Minnesota.

In 1976 Minnesota was presented with a unique proposal. As a bicentennial gift, the country of Norway presented $200,000 to the State. This money, if matched by a State appropriation, was earmarked to create a Minnesota Health Resource, Education, and Training Center for the Handicapped patterned after Norway's Bietostölen Health Sports Center. This was a totally new concept in care for the handicapped, centering on health sports training.

My interest in this concept was threefold: First and foremost, as chairman of the health and welfare committee, I felt that this new approach to health care for the handicapped was a concept whose time had arrived. It concentrated on the philosophy that individual responsibility is the key to a healthy lifestyle: It stressed health promotion, rather than sickness treatment, for the handicapped, (Minnesota continues this tradition today in the Governor's Council on Health Promotion and Wellness). Secondly, I was interested in this concept from a vocational standpoint, in my role as an educator in the vocational system. Lastly, my Scandinavian heritage told me that this would be an excellent concept to bring to this Scandinavian State.

Consequently, I carried the legislation in the Minnesota House to provide a matching appropriation of State funds to create Vinland. House File 917 in 1977 appropriated $200,000. At the time of the legislative hearings, testimony was presented concerning the uniqueness of the Vinland concept, the lack of similar institutions in the United States, the established research basis for the concept, and the potential for reducing health care costs. Through a comprehensive program involving rehabilitation, health education, and health care research the Vinland National Center would improve the social, mental, and physical health of handicapped people from Minnesota and from throughout the United States.

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Again, I appreciate this opportunity to speak to you on the importance of Vinland, and to convey my continued full support of this center. As I said in 1977 when I first proposed the Vinland bill, the Vinland Center is a model for the life-style enhancement of all Americans; its impact upon life quality extends far beyond the handicapped to the entire population. Passage of this legislation will again demonstrate that Minnesota's quality of life is second to none.

Thank you, and I would be happy to answer any questions.

Mr. **Murphy**. Dr. Dahl, the director of the Vinland National Center.

STATEMENT OF TOR DAHL, DIRECTOR, VINLAND NATIONAL CENTER, ACCOMPANIED BY JOAN SAARI, DIRECTOR OF OPERATIONS

Dr. **Dahl**. I am serving on the board. I am an associate professor in the school of public health at the University of Minnesota. I cochaired the first International Conference on Lifestyle and Health, I edited the proceedings of the White House briefing on the Vinland National Center, and I have been engaged in the efforts to establish the Vinland National Center since it was first proposed in 1974.

In my academic and research career I have published numerous papers and reports on the topics relevant to our hearing today. My inclination is to cite the research and the references upon which the Vinland National Center program is formulated. But that would be testimony coming from the head. My statement today comes from the heart, because Vinland has changed me, and enlightened me, and given me a far deeper understanding than I could possibly have gained from statistics and data alone. And while I shall still be pleased to supply the subcommittee with all the data that it may need, I agree with him who said that statistics are people with their tears dried off, and today I shall talk about people and what they can do for themselves and what they can do for us all.

It has been said that the force of the waves is in their perseverance. For 8 years the efforts to build Vinland have persevered. They have created an army of volunteers, some 10,000 Americans, who previously had no contact with handicapped individuals, but who now do. These efforts have taught able bodied and disabled to live and work and play together. Sometimes these interactions have been truly inspired and lead to unbelievable feats, such as the attempt to climb Mount Rainier by blind and disabled people, or the 41-day skiing trip across the Arctic tundra of Finland, Sweden, and Norway by a Vinland group, or the tandem bicycle ride around the world by a Vinland enthusiast, or his equally impressive feat of a horseback ride from the Pacific to the Atlantic. But these events are just the extreme expressions of a movement far deeper and wider and most important than the efforts of these exemplary individuals. We are talking about the future of life and health enhancement in the United States.

In May of this year I had the honor of serving on a special panel chaired by the commissioner of health of Minnesota, Dr. George R. Petterson. The panel's task was to identify and rank the most pressing health problems now facing the State of Minnesota, and, by implication, the Nation. In our deliberations we took account of the reports and studies that have been published by the Department of Health and Human Services, by the Surgeon General, by Congress, by our own health department, and many other sources. In particular, we looked for precursors of disease—not just simply morbidity and mortality data, but those circumstances that eventually cause the morbidity and mortality that we were trying to improve.

Perhaps to the surprise of many, and this will be published in October, Mr. Chairman, our key problems turned out not to be heart disease, or cancer, or stroke. Our key problems are the circumstances that lead to those conditions, namely: Smoking, alcohol and drug abuse, injuries, nutrition, environment, stress, and the activity levels we engage in; and in that order.

To my knowledge Vinland was the only organization that enunciated all of these principles back in 1975—that for blind and disabled people to live rich and long and productive lives, they must become active, they must learn how to deal with stress and a hostile environment, they must learn about nutrition, and how to protect themselves against accidents, and the debilitating effects of chemical dependencies. The Vinland National Center was a vision of the health care intervention strategy of the future: the inexpensive, effective, and remarkably accurate approach to dealing with the most basic of all problems of the disabled: the need to be healthy. This need precludes the need of conventional rehabilitation, and it is often not met even after conventional rehabilitation has been completed. The Vinland National Center idea is an idea whose time has come, and it is testimony to the effectiveness of the Vinland programs that we may describe them by remembering John Ruskin's words: When love and skill work together, expect a masterpiece.

So, with love and skill and dedication we have seen blind and disabled people enter into new partnerships with able-bodied people, giving of themselves and receiving in return, gaining a new understanding and laying a foundation for further growth; and creating a new synthesis of factors that embraces the crucial aspects of what we now know directly addresses the health status of this Nation. It is an extremely challenging educational problem to communicate the essence and effects of the Vinland programs to a larger audience, Mr. Chairman, but people like the Honorable Arlen Erdahl have taken the time and effort first to find out about the importance of these ideas, and then to visit the original Beitostölen Health Sports Center in Norway to see for themselves.

Because of Vinland's Norwegian progenitor, we are not taking any risks in this matter—we are talking about a program that has proven itself at home and abroad, and which is now being replicated in other countries. And because of what we know now about our Nation's health problems, Vinland is central to the reeducation effort that must precede a fundamental improvement of the health of the disabled, and the health of all Americans. And we must not only look at the cost of building and running Vinland, but at the cost of not building Vinland. For every year that passes without the presence of such programs, we are incurring millions of dollars in added health care costs, in years of premature mortality, in uncounted preventable absences from work, and in lost satisfaction and vitality.

This is one way the handicapped citizens of our country can show us all what our health care institutions will look like in the future. In the process we shall all be better off, and we shall rid ourselves of the notion that handicapped citizens somehow are not worthy of these programs, or entitled to the opportunities available to our able-bodied citizens. The Vinland philosophy embraces the statement of Henry Van Dyke: "Use whatever talent you possess. The woods would be very silent if no birds sang there except those that sang best."

Vinland is located on Lake Independence. It is a national center dedicated to the idea that we are all temporarily able bodied—that we all have a yearning to sing, to live, to grow and to be part of the pulsating life of our Nation. This is also the path to individual health and contribution and true independence. It was the best gift that a friendly country could give us during the American Bicentennial. We should treasure that gift, and make it work its beneficial effects throughout our society and our Nation.

Mr. MURPHY. Thank you very much, Doctor.

[The prepared statement of Tor Dahl follows:]

PREPARED STATEMENT OF TOR DAHL, ASSOCIATE PROFESSOR, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF MINNESOTA

My name is Tor Dahl. I am an associate professor in the school of public health at the University of Minnesota. I cochaired the First International Conference on Life-Style and Health, I edited the proceedings of the White House briefing on the Vinland National Center, and I have been engaged in the efforts to establish the Vinland National Center since it was first proposed in 1974. In my academic and research career I have published numerous papers and reports on the topics relevant to our hearing today. My inclination is to cite the research and the references upon which the Vinland National Center program is formulated. But that would be testimony coming from the head. My statement today comes from the heart, because Vinland has changed me, and enlightened me, and given me a far deeper understanding than I could possibly have gained from statistics and data alone. While I shall still be pleased to supply the subcommittee with all the data that it may need, I agree with him who said that statistics are people with their tears dried off, and today I shall talk about people and what they can do for themselves and what they can do for us all.

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Mr. MURPHY. Dr. Keith Vanden Brink, of the Gillette Children's Hospital in St. Paul.

STATEMENT OF KEITH VANDEN BRINK, M.D., GILLETTE CHILDREN'S HOSPITAL, ST. PAUL, MINN.

Dr. VANDEN BRINK. Thank you for the opportunity to testify before your committee on behalf of handicapped individuals. I serve as medical director of Gillette Children's Hospital, a regional center for children and young adults with handicaps.

Gillette currently serves 6,200 young people with a variety of handicapping conditions. We often see the children in the first stages of their life, and attend to their medical and rehabilitative needs immediately, continuing treatment until the age of 21. Beyond Gillette, Minnesota has many other fine rehabilitation programs. Yet like Gillette they are hospital models. It is our job to perform the medical and surgical aspects of their treatment, but in so doing perhaps we lose some of our credibility as teachers of independence.

Our image-oriented society has made it extremely difficult for the handicapped individual who deeply feels that difference, so they usually fear a return to their community. Whether this handicap is an acquired one by reason of traumatic injury or that individual is born with a limiting condition, they feel a loss of self-worth and maintain a limited knowledge of their abilities. Although rehabilitative medicine has made great strides in the medical and surgical management of many problems of the handicapped, the focus is still myopic. Perhaps our efforts have been too traditional by giving limited tasks, further emphasizing to the individual that they have a limited potential. Throughout our country there are many excellent rehabilitation facilities with large rooms and hallways from which good rehabilitative progress is said to have been made, but upon discharge of these individuals to their home there is often self-imposed isolation due to inaccessible buildings, disinterested communities, and lack of work, resulting in "too much time on their hands." It is now time to introduce clear goal-setting criteria for these individuals, with an emphasis upon accomplishment through motivational training.

The medical literature promotes "optimal function" as the criteria of rehabilitation efforts; but what is the precise definition of these terms? Is it the best I can do at my facility, and therefore is it optimal? There are certain clear anatomic reasons for real limitations, but whose definition of the end point of rehabilitation do we accept? We have taken too long to progress from menial tasks and institutionalization to vocational training and mainstreaming. The concept of healthsports at Vinland is the need of the future to promote more lasting self-worth through healthful living with enhanced mental and social development. We all benefit when we help our fellow man to achieve his maximum potential. We at Gillette are committed to the program best for our children.

At Gillette Children's Hospital, I have reviewed our program of rehabilitation, and realize certain aspects are missing. While offering excellent medical and surgical management, excellent physical and occupational therapy with social and psychological services, some of our teenagers still have existing problems with self-image and self-worth. We teach children their basic skills, adaptive swimming, baseball or volleyball, and involve them in low-level competition against their peers and among themselves. Why then do some of the children still have the aforementioned problem? What are we overlooking? What are the kids missing? The answer is a persistent lack of positive self-image and continued motivation. We too often concentrate on physical factors to the exclusion of those life lasting qualities gained and retained through achievement. Those same psychological factors operative during unemployment and other periods of inactivity among our able-bodied, affect our handicapped on a consistent basis. Achieving through sports produces a positive self-image leading eventually to positive lifestyles, job training, job acquisition, and productivity hitherto infrequent. We at Gillette wish to produce a lifestyle during their formative years that has a greater opportunity for lifelong maintenance. Vinland uniquely offers this possibility to our children. Expenditures now will be small compared to the productivity of the well-motivated and handicapped individual in the society of the future. There is ample evidence that the handicapped individual has an unexcelled work record.

Easily understood for most is the athlete and his accomplishments prior to a disabling injury. Following a primary period of denial, depression, and anger, we see this give way to a positive attitude with a return to sports and employment. Representative of such individuals are those highly motivated personnel making up the staff of Vinland National Center. Their difficult task is to impart that attitude and drive to others. More difficult to understand are those children born with multiple handicapping conditions as we see at Gillette, kids who have avoided sporting goods sections in stores and longingly stared at items they felt were forever out of their reach. To help them achieve in areas of life that they thought impossible in the past will have more lasting effect than thousands of dollars spent on institutionalization. Personnel at Vinland are uniquely qualified to impress our child with the importance of caring for him or herself, since that person is often talking from experience.

Healthsports as espoused by Vinland National Center will provide a unique base to build upon. Rehabilitation in all handicapped individuals begins with doing one small thing well and expanding upon that. When a child sees other handicapped individuals striving for goals—skiing, going miles over rough terrain in a wheelchair, overcoming obstacles to achieve those goals, he uses these people as role models. He develops enough confidence to do it himself, and with that confidence comes independence. We must continue to emphasize the similarities with normal persons and not their differences. Educational pursuits and the acquisition of a degree, getting one's paycheck, and going swimming are only a few examples of that. Handicapped children should be engaged in competitive sports at an early age and not told to stay away. Subtle social and personal benefits accrue from this activity that is usually denied them. Healthsports can build a basis of understanding between the handicapped and able bodied. We are in a lifelong struggle to educate the public in the work and potential productivity of these individuals. Such is the educational effort of Vinland National Center giving their charges the proper opportunity to achieve.

Obesity has altered many a child's ability in our population to ambulate and to stay active. The Vinland emphasis on nutrition and a concern for one's own health is a must for our children. Pressure ulcers from prolonged sitting are another costly problem, and can be greatly helped through weight control as well as proper nutrition and patient education in the importance of self-maintenance of their health and body.

In summary, Vinland will offer a unique concept to our Gillette patients to enhance our present rehabilitative efforts. They can provide excellent education for our rehabilitation professionals, the child's parents, as well as the patients themselves creating a new and exciting era in rehabilitation medicine. Gillette Hospital is extremely active through our engineers in the design and manufacture of adaptive equipment. Vinland is uniquely qualified to work with individuals with that special adaptive equipment and we hope to work with them in the future for further design and implementation of other equipment. More importantly, Vinland Center is national in scope. Through their emphasis on healthsports, nutrition, and a positive lifestyle, they will be of inestimable benefit not only to our patients in Minnesota but to each State in our Union. Such concentration on healthsports and positive lifestyles can be carried beyond Vinland to be implemented in the YMCA's of America and other such facilities, giving our handicapped population greater opportunities than they have ever enjoyed, and help them to be productive members of our society.

We believe in the Vinland program, and intend to involve our patients.

Mr. **Murphy**. Thank you very much, Dr. Vanden Brink.

[The prepared statement of Keith Vanden Brink follows:]

PREPARED STATEMENT OF DR. KEITH VANDEN BRINK, MEDICAL DIRECTOR, GILLETTE CHILDREN'S HOSPITAL

Thank you for this opportunity to testify before your committee on behalf of handicapped individuals. My name is Dr. Keith Vanden Brink and I serve as Medical Director of Gillette Children's Hospital, a regional center for children and young adults with handicaps. Gillette currently serves 6,200 young people with a variety of handicapping conditions. We see the children in the first stages of their life and attend to their medical and rehabilitative needs immediately continuing treatment until the age of 21. Beyond Gillette, Minnesota has many other fine rehabilitation programs. Yet like Gillette they are hospital models. However, it is our job to perform the medical and surgical aspects of their treatment but in so doing perhaps we lose some of our credibility as teachers of independence.

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Mr. MURPHY. The final panelist's biography is impressive. Mr. Philip Carpenter, who is the president of the International Wheelchair Road Racers Club.

STATEMENT OF PHILIP CARPENTER, PRESIDENT, INTERNATIONAL WHEELCHAIR ROAD RACERS CLUB, INC.

Mr. CARPENTER. I am Phil Carpenter, president of the International Wheelchair Road Racers Club, Inc., IWRRC, a nonprofit corporation which was officially formed in December 1980 by a group of wheelchair racers and their avid supporters from across the United States and beyond.

The IWRRC was conceived by wheelchair road racers responding to the need for such an organization to represent their common interests.

The year 1981 was designated as International Year of Disabled Persons by the United Nations. The IYDP theme was, "full participation of disabled persons in the life of their society."

With the title of "Special Ambassador" to the U.S. Council for the IYDP, George Murray and I set out upon the first educational project of the IWRRC. The historic event known as the "Continental Quest" took us 3,442 miles from Los Angeles to the United Nations Building in New York City by means of manually powered wheelchairs. We completed this journey to demonstrate the physical capabilities of disabled persons.

Today, my mission is to share with you my perspective on the rehabilitative services currently available in the United States and demonstrate how the Vinland National Center offers practical and needed additions to the rehabilitation process.

I did my initial rehabilitation at Craig Rehabilitation Hospital, Denver, Colo., which at the time was nationally recognized as the best rehabilitation facility in the country. Even then, there were no continuing rehabilitation programs available for me.

My personal experience and successes have come from years of experimentation. The Vinland National Center provides programs that give the much-needed support required during those first several years of change and adjustment.

At present, the rehabilitation process consists of three stages. At the onset of a disabling injury or disease, an individual's immedicate medical needs are provided for in an acute-care hospital, stage 1.

Once the condition is stabilized, the patient is transferred to a rehabilitation facility for stage 2. This is a time of reorientation and relearning during which a person learns the basic skills of daily living. An extremely busy period, basic rehabilitation leaves very little time for the development of social and physical skills which are necessary for an effective transition back into the mainstream of society.

Stage 3 is the readjustment to the home environment and not all individuals are equipped with the tools, knowledge, incentive, and support to move from the rehabilitation environment to full participation in the community.

Stage 3 is a period of questioning and examining options in the areas of vocational, recreational, social, and cultural activities. Vinland can provide the individuals with the opportunity to examine the many pieces of this puzzle, arranging them and testing them to effect a successful transition into the able-bodied world.

Physical activities, sports, and recreation skills are more than fun and games. They can be the source of renewed self-confidence and improved self-esteem and the motivation to return to employment, maintaining and developing relationships with family and friends.

In addition, healthsports can link a disabled person with others who are disabled in order that support, activities, and experience can be shared.

Experience to date with health promotion training programs shows that everyone benefits when people with neurological, physical, developmental, and mobility disabilities are able to achieve personal fulfillment, opportunity for employment and increased social and mobility options.

Vinland is a national center that is developing and demonstrating methods and concepts that can be implemented at local rehabilitation agencies throughout the Nation.

In the Vinland National Center's 1981–82 pilot programs, its national scope has proven valid as participants came to Vinland representing 18 States.

In Vinland's national Outreach program professional presentations at workshops and seminars were conducted by Vinland staff in 37 cities from coast to coast, reaching over 3,600 persons. More than 7,500 manuals have been printed on 6 different activities offered by Vinland and 6 new manuals are now being prepared by consultants and staff for completion this fall, 1982. Offsite health sports instruction and clinics were offered in seven locations ranging from Spokane, Wash., to Gettysburg, Pa.

In addition, Vinland is establishing important referral and followup professional relationships with community-based rehabilitation and recreation organizations nationally.

IWRRC is an example of this type of cooperation. We are using Vinland resources and Vinland is using our resources to develop this part of wheelchair road racing in order to: Promote awareness and understanding of the abilities of persons with disabilities; promote physical fitness, especially in the disabled community; promote, protect and perpetuate the sport of wheelchair road racing in the United States and elsewhere; provide educational and technical assistance to race directors regarding wheelchair divisions of their races; provide educational and technical assistance to wheelchair road racers and potential wheelchair road racers of all ages.

Wheelchair athletics is in a rapid growth period. For most persons, wheelchair athletics opens the door to countless other recreational opportunities. A Vinland program isn't an end upon itself, but is merely a beginning. Success breeds success.

In the past 50 years, the United States through congressional policy and action, has helped remove many medical, vocational, educational and access barriers from the paths of its disabled citizens. Now, the opportunity is at hand to remove the attitudinal, fitness and lifestyle barriers that still exist and discourage independent living.

I have the privilege of witnessing a very exciting time in the lives of our 35 million disabled persons. In the past 5 years, there has been a phenomenal growth of interest in disabled sports and recreation. New companies manufacturing adaptive sports equipment can no longer keep pace with the demand. The able-bodied running community has gone from acceptance of wheelchair racers to the welcoming and the promotion of wheelchair divisions of local races.

The need for the programs sponsored by the Vinland National Center is growing and this growth must be matched by program operation and construction. I urge you, through congressional action, to firmly establish the Vinland National Center so that the United Nations International Year of Disabled Persons goal of "full participation of disabled persons in the life of their society" will become a reality in our Nation.

Thank you.

[Material submitted by Phil Carpenter follows:]

PREPARED STATEMENT OF PHIL CARPENTER, PRESIDENT, INTERNATIONAL WHEELCHAIR ROAD RACER CLUB, INC.

I am Phil Carpenter, President of the International Wheelchair Road Racers Club, Inc. (IWRRC), a non-profit corporation which was officially formed in December 1980 by a group of wheelchair racers and their avid supporters from across the United States and beyond. The IWRRC was conceived by wheelchair road racers responding to the need for such an organization to represent their common interests as well as the interests of the running community.

Membership in the IWRRC includes wheelchair road racers of varying nationality, age, sex, type and severity of disability. and athletic caliber, as well as road race directors, able-bodied and disabled athletes of all types, supporters of (wheelchair) sports in general and road racing in particular, professionals and volunteers involved with physical disabilities and members of the disabled community worldwide, family, friends, and others who just happen to care.

1981 was designated as International Year of Disabled Persons by the United Nations. The IYDP theme was, "full participation of disabled persons in the life of their society." With the title of 'Special Ambassador' to the U.S. Council for the IYDP, George Murray and I set out upon the first educational project of the IWRRC. The historic event known as the 'Continental Quest' took us 3442 miles from Los Angeles to the United Nations Building in New York City by means of manually-powered wheelchairs. We completed this journey to demonstrate the physical capabilities of disabled persons.

Today, my mission is to share with you my perspective on the rehabilitative services currently available in the United States and demonstrate how the Vinland National Center offers practical and needed additions to the rehabilitation process. I did my initial rehabilitation at Craig Rehabilitation Hospital, Denver, Colorado, which at the time was nationally recognized as the best rehabilitation facility in the country. Even then, there were no continuing rehabilitation programs available for me.

My personal experience and successes have come from years of experimentation. The Vinland National Center provides programs that give the much needed support required during those first several years of change and adjustment.

I should like to examine with you three important points.

1. How does the concept of healthsports affect a disabled person.
2. Who benefits from this type of program.
3. What is the need for a national resource.

At present, the rehabilitation process consists of three stages. At the onset of a disabling injury or disease, an individual's immediate medical needs are provided for in an acute-care hospital (Stage One). Once the condition is stabilized, the patient is transferred to a rehabilitation facility for Stage Two. This is a time of re-orientation and re-learning during which a person learns the basics of daily living. An extremely busy period, basic rehabilitation leaves very little time for the development of social and physical skills which are necessary for an effective transition back into the mainstream of society.

Stage Three is the readjustment to the home environment and not all individuals are equipped with the tools, knowledge, incentive and support to move from the rehabilitation environment to full participation in the community. Through vocational rehabilitation and training, technical education is gained. Stage Three is a period of questioning and examining options in the areas of vocational, recreational, social and cultural activities. Vinland can provide the individuals with the opportunity to examine the many pieces of this puzzle, arranging them and testing them to affect a successful transition into the able-bodied world.

Physical activities, sports and recreation skills are more than fun and games. They can be the source of renewed self-confidence and improved self-esteem and the motivation to return to employment, maintaining and developing relationships with family and friends. In addition, healthsports can link a disabled person with others who are disabled in order that support, activities and experience can be shared.

The programs offered by Vinland can benefit all disabled American citizens. Disabled persons are each different and unique, however, several major groupings in their relation to the Vinland National Center bear mentioning.

First, are those persons who have been recently disabled. Through healthsports training, recently disabled individuals can examine their options with regard to their new physical, social, and emotional lives; arrange and test these new options to effect a successful transition to their new world. The period that follows discharge from the hospital is a long and bumpy road. There exists a need for Vinland to provide continuing rehabilitation opportunities for these persons. The need has not been created by advancement of sports or a gift from Norway, but rather by an evergrowing interest in sports and recreational activities.

A group that is not so visable is children. I had an opportunity to speak at several grade schools in Springfield, Missouri. As my 'Continental Quest' slide show was in progress, one teacher observed a wheelchair-bound fourth grade boy roll up his T-shirt sleeves to expose his muscles when he saw the slides of our Rocky Mountain crossing. He had obviously realized that he, too, was capable of physical feats. His able-bodied classmates also realized this as they excitedly talked together during the following autograph session.

Third are the persons who have been disabled for a long period of time, live a sedentary lifestyle and are no longer actively involved with a rehabilitation center. In a recent study conducted in California, the researchers found that the main reason for disabled persons to be chronically unemployed is due to their inability to relate to able-bodied co-workers, not their inability to perform the job nor their inability to get to work. The healthsports concept is aimed at introducing or re-introducing the social and recreational skills necessary for disabled persons to work and recreate with able-bodied co-workers, friends and family.

Fourth, are those persons disabled by war-related injuries. These persons can obviously benefit from the above mentioned physical, social and vocational benefits but, perhaps more important, is the impact healthsports have upon the emotional health of a disabled war veteran. A disabling injury, especially if related to violence, leaves an emotional scar that is often more handicapping than the physical impairment. Healthsports activities are designed to restore self-confidence, an improved self-concept and promote an attitude of "If I can do this, than I can do anything". Healthsports should never be viewed only as fun and games, but rather viewed by its total impact on the vocational, physical, social and emotional health of a disabled person.

Finally, are the family, friends, and American taxpayers. Experience to date with health promotion training programs shows that everyone benefits when people with neurological, physical, developmental, and mobility disabilities are able to achieve personal fulfillment, opportunity for employment and increased social and mobility options.

Vinland is a national center that is developing and demonstrating methods and concepts that can be implemented at local rehabilitation agencies throughout the nation.

Although it is true that it is in the best interests of disabled people that rehabilitation and recreational services be provided at a local level, it should be pointed out that without the leadership provided by Federal Government and Congress, the United States would not have today's high quality rehabilitation services. Vinland is a national center that is developing and demonstrating methods and concepts that can be implemented at local rehabilitation agencies throughout the nation.

In the Vinland National Center's 1981/82 Pilot Programs, its national scope has proven valid as participants came to Vinland representing 18 states. Thirteen colleges and universities sent student interns to study healthsports and learn teaching and counseling skills in an active and dynamic setting. In Vinland's National Outreach Program professional presentations at workshops and seminars were conducted by Vinland staff in 37 cities from coast to coast, reaching over 3600 persons. More than 7500 manuals have been printed on six different activities offered by Vinland and six new manuals are now being prepared by consultants and staff for completion this fall, 1982. Off-site healthsports instruction and clinics were offered in seven locations ranging from Spokane, Washington to Gettysburg, Pennsylvania.

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- Promote awareness and understanding of the ABILITIES of persons with disabilities;
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The need for the programs sponsored by the Vinland National Center is growing and this growth must be matched by program operation and construction. I urge you, through Congressional action, to firmly establish the Vinland National Center so that the United Nations International Year of Disabled Persons goal of "Full Participation of Disabled Persons in the Life of their Society" will become a reality in our nation.

international wheelchair road racers club inc.

BIOGRAPHICAL INFORMATION
Phil Carpenter

Before entering the U.S. Navy in 1967, he was working as a night club musician. He completed electrician's and damage control schools before serving a tour-of-duty in Viet Nam and advancing to senior electrician aboard the U.S.S. Farragut.

Upon discharge, he began working for General Telephone Co. Then on April 29, 1972, his back was broken in a waterskiing accident on Lake Tarpon near his home in Holiday, Florida. The next three months were spent at Craig Rehabilitation Hospital in Denver, Colorado. It took three years before wheelchair basketball began a renewed interest in sports for Phil. He also participated in regional and national track and field meets beginning in 1977.

The track held a particular interest for him, so in the fall of 1977, he began training for his first road race which was the Orange Bowl Marathon held in Miami, Florida on December 26, 1977. He entered the first of four consecutive National Wheelchair Marathon Championships in April of 1978 at Boston, Massachusetts.

Two years later, he won the Class III National Wheelchair Marathon title and in 1981, he won both the Class III National Championship and the Class III World Wheelchair Marathon Championship. The World Championships were held during the Fourth Annual Orange Bowl Marathon in January.

With the title of "Special Ambassador" to the U.S. Council for the International Year of Disabled Persons, Phil began the historic event known as the "Continental Quest". On April 11, 1981, accompanied by George Murray, he left Los Angeles to

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travel the 3400+ miles to the United Nations Building in New York City. This was the first-ever attempt to cross the North American Continent by using manually powered wheelchairs.

Phil has coached both able-bodied and disabled runners and is the President of the International Wheelchair Road Racers Club. His sports activities have now broadened to include racquetball in his repertoire.

He is proud to serve as a member of the National Easter Seal Society Sports Council, and believes that physical fitness is as essential for good mental health as it is for the body's well-being.

Phil has worked with Special Olympics in Pasco County, Florida in 1981 and has volunteered for the 1982 program.

He is also volunteering work with the Florida Spinal Cord Injury Advisory Council in formulating their State Plan to aid in the development of initial medical care, rehabilitation services, and vocational training for new spinal cord injured clients.

On January 17, 1982, Phil won his second consecutive Class III International Wheelchair Marathon Championship title at the Orange Bowl Marathon in Miami, Florida.

As a result of his performance in the 1982 National Wheelchair Games held in Marshall, Minnesota, he was selected to the U.S. Wheelchair Team. Competing in the VII Pan-American Wheelchair Games in Halifax, Nova Scotia, he medaled in track events.

Mr. Murphy. Thank you very much, Mr. Carpenter.

Dr. Dahl, I don't recall your getting into the financial support of Vinland. Would you give me some insight on that, total dollars, where they come from, percentages?

Dr. Dahl. I am so glad you asked that question. There are a number of issues that were raised this morning and our staff put together a response to every single one of them. I am sure you will be delighted——

Mr. Murphy. I will have to think of different questions then.

Ms. Saari. Perhaps I can answer that more directly. I am Joan Saari, the director of operations of the Vinland National Center, and I have to do with the day-to-day things of putting money into the checking account and drawing the checks to come out, so I can probably speak very accurately on where our funding comes from.

Right now, primarily, our Federal funding has come from competitive grants, where we have competed under RSA, sections 316 and 311 grant proposals.

Our private-sector money has been coming from national organizations. I computed this morning that 96 percent of our private-sector funds come from nationally based organizations.

AT&T is a sponsor of the Vinland Center, the 3M Corp., the Curtis-Carlson, the Sons of Norway organization, which has 300-some lodges from coast to coast, are prime examples of our support.

Our private-sector support is coming from fraternal organizations such as the Sons of Norway, the Lion's Clubs and that type of thing. We have support coming from major national corporations and we have a lot of funding coming from the grassroots support.

We have just conducted a campaign called "Put a Foot on the Vinland Trail System." Right now, just through private sector type of support, people reading the newsletter are sending in $7. We had a woman who wrote an apology saying she couldn't afford $7, could we take $3.50 to put half a foot on the trail system.

We have only received 4 percent of our private contributions from Minnesota organizations. To give it in dollars, our total operational budget this last year was $478,000; $382,000 of that came from the Federal Government on competing grants and the rest came from the private sector.

Mr. Murphy. Thank you.

I think you have gotten to the other questions that I was going to ask. I am going to read your document.

Ms. Saari. I think that answers most of the questions raised.

Mr. Murphy. OK. I will probably have some written questions for you, Dr. Dahl, and also Representative Swanson, I may have a couple with regard to the enabling act, the certificate, and I will drop those in the mail to you and trust you will get back to us.

Thank you.

Mr. Erdahl.

Mr. Erdahl. Thank you very much, Mr. Chairman.

As the original sponsor of H.R. 6820, obviously I am very pleased with the testimony that we have had from the individuals here. I would like to underscore what Joan Saari just said. She mentioned the various organizations that are backing this endeavor. I think we saw some of that from the brief tour that pointed out the National Guard unit which constructed some of the trial system.

I think you neglected to mention that organized labor has been involved, the fraternal organizations, corporate world, private citizens. There are a lot of people from a broad range of activities that have been involved.

Frankly, I was not aware—I knew it is a national center, obviously for people outside the State of Minnesota. I was surprised at the percentage you mentioned. Let me ask a question that came to mind, and I will direct this to Dr. Dahl—as you indicated and others of us are aware, this is patterned after the concept of wellness, the sports center in Bietostölen in Norway.

We as Americans make up about 6 percent of the world's population. You mentioned that this concept had been exported to other countries.

Are you aware what other countries might be doing in the same area, because unfortunately, people with handicaps are found throughout the world and in some places in the developing nations they are still very tragically neglected.

Dr. **Dahl**. Canada has determined that such a center will be built. Contact has been made by Norway with countries such as Bangladesh and countries in Africa, and visits have been made to the Soviet Union, all of which expressed interest in the concept and a new appreciation of it.

I want to make clear that we all have to die of something and the issue of making our existence on their Earth better is similar to the epitaph that Lauren Ashley had on his gravestone, "We love the Earth, but we couldn't stay."

We are aware that we will die of something, but we have to spawn strategies and the quality of life between that is the foundation of Vinland, and hence, the new awareness of what creates our health and our health care costs.

The interest from the other countries came primarily, I think, because of the explosion in the literature of research in this area that verifies the direction of Vinland and its accuracy in developing a healthy population.

Mr. **Erdahl**. Thank you very much. Maybe I could, Mr. Chairman, direct a question to Ms. Saari. As we have gone along with this program, and I think there has been criticism that we haven't seen enough program development and it seems to be taking a long time in the planning stage.

I think in recent months we have seen more encouraging development and the joint facilities across the way, but could you, for my benefit and for the record, bring us up to date as to how we are doing right now as far as program is concerned?

I think the concept involved is not only helping some people in Minnesota, but training people who can reach out and help with training other people throughout the country.

Ms. **Saari**. Vinland is a national center, and to be a national center, no matter how many beds we would locate here, we still couldn't significantly dent the 35 million disabled people that are in the United States.

So, therefore, in our program development, which took a long time, but that is good because we know exactly what we need, we are responding to needs assessments that have been conducted.

We have been looking and discussing with our staff members, and I think it is important to point out that 50 percent of our staff are people with disabilities. I think it is hard to duplicate existing services when you have nine people on your staff as part of rehab.

They have a good daily touch with what is involved and what is necessary. So the Vinland pilot programs were funded by pre-Voc Education Services Administration. Thirty-three projects were selected. Vinland was two of those. You say the construction project at the site, and the pilot programs are just completing.

As part of that, we offered a healthsports program. That included health sports, activities designed to improve physical fitness, the social fitness, and the emotional fitness of a disabled person, the life enhancement looking at personal development, assertiveness, communication skills.

We brought in people from 18 different States. I have to admit that we as a staff, when we sent out the notification, we received notification October 15 that we were funded for October 1 and that we had to have our programs up, running, down, evaluated, and completed by September 30 of the following year.

That was a real challenge. We announced our programs at the first of November. That gave us 2½ months and we wondered, are we going to have a party where nobody comes? Two years ago, I heard a lot of concerns that I heard this morning at the hearing where we got the land rezoned.

At that time I said yes, the concerns are valid, the things that you heard this morning. The pilot programs were funded by RSA to test, can a national sports center work in this country?

We have enjoyed the success. All of our programs were conducted, we did not have to cancel any because of lack of enrollment. As a matter of fact, we had to turn people away in wheelchairs because the YMCA made great modifications to the facility, but still, we are restricted to six wheelchair users at the YMCA camp.

We were very pleased with the results of the attendance at the programs. We started conducting research doing fitness profiles and attitudinal studies. One person did a doctoral dissertation on attitude changes.

In 3 short weeks, there were some very massive changes in both the philosophical and the physiological and the psychological parts of the person and many past participants who have come today, and I want to thank them for doing that, and you will have an opportunity to talk to them about that.

Our training manuals are another part of the national outreach, our fourth component. We are working with organizations where we are training their staff people and then the center serving as a community-based program for our participants when they return to the community.

This has been a success. Our training manuals are being purchased by people all over the country who are just interested in getting the materials so that they can conduct healthsports programs there.

That has been a success. The professional education, we had 13 colleges and universities that sent students to Vinland from Oregon to New Hampshire, that sent their students here to train at the Vinland Center. We had physical therapists, recreation therapists coming from Oklahoma to Vinland to learn so that they can go back and add these programs to their place.

The sixth component is research. The results were just presented at the World Convention on Better Teaching of Health and Physical Fitness in Boston University, and we received outstanding acceptance and interest in this concept.

So I would say that in the last 6 months under the RSA pilot programs, Vinland has proven its validity, and we have increased such a need and such a demand for the healthsports center that I feel we are justified now to come back after our years of planning, our component and program testing to say the national center needs more than a house that has been converted to a conference center, a 4-stall garage that has been converted into a 11-desk office.

We spend a lot of time on the bus shipping people back and forth to the YMCA, a lot of time spent by having to use facilities that aren't completely adequate, and I think the time has come that Vinland can raise the matching funds that we need to be self-sufficient after 5 years.

We do have different State organizations paying for participants to stay here. One of the questions raised at the hearing this morning, and I will save Pat some work, that State agencies can pay for services in other States.

Illinois did pay for one of their client's stay here and paid for a summer program in addition. Surgery insurance paid for the tuition and travel for participants coming here. So in that quick report that I put together over the lunch hour, you can see the list of how we do plan to be self-sufficient.

Mr. **Erdahl.** Thank you, Joan.

Mr. Chairman, with that, I would ask unanimous consent that the statement be included as part of the record, the questions and answers.

[The information referred to above follows:]

Prepared Statement of Joan Saari, Director of Operations, Vinland Center

RESPONSES TO MORNING TESTIMONY

This morning three persons voiced their concerns against the funding of the Vinland National Center. I would like to respond to these concerns, answer their questions and voice my concern with regard to the accuracy of their testimony.

Joyce Vincent and Clint Schultz both voiced the same concerns today that I heard two years ago at Vinland's Conditional Use Permit Hearing at the City of Independence. Those concerns were valid at that time, however two years of programs have answered those concerns and questions. Ms. Vincent and Mr. Schultz have not visited Vinland during the last two years, but they have studied recent Vinland National Center materials. In an effort to lay these issues to rest once and for all, I will address some of the major points raised in this morning's hearing.

To address these issues, I should like to ask some questions and answer them myself.

Question 1. The national scope of the Vinland National Center will not work! I should like to ask, how many states were represented by participants during the pilot programs?

Answer. 18.

How many professional relationships have been established between the Vinland National Center and community-based organizations to provide training materials and support?

Answer. 10 per year.

How many off-site programs were conducted by the Vinland National Center across the United States?

Answer. 14.

How many training manuals were published and are now being disseminated nationally?

Answer. 7,500.

Who will pay for travel?

Answer. During the Pilot Programs, individuals of Detroit Wheelchair Athletic Association, Casa Colina Rehabilitation Hospital, CA; Boston University Hospital; Toledo Society for the Handicapped are only a few of the sources. In addition, the Sons of Norway paid travel scholarships for persons in the community.

The Vinland National Center has during its pilot program proved its validity as a national center.

Question 2. Vinland National Center is a duplication of services. If the Vinland National Center is a duplication, who do Sister Kenny, Gillette Children Hospital, Minnesota DVR, the YMCAs, United States Association of Blind Athletes, International Wheelchair Road Racers Club, National Association of the Deaf and other national and local organizations support the Vinland National Center?

Answer. As Phil Carpenter and Dr. Vander Brink have explained in their testimony, the Vinland National Center complements, not duplicates existing programs and facilities.

Vinland is a part of the continuim of the rehabilitation process, the same process Courage Center, Sister Kenny and the other fine rehabilitation organizations in the local area. Vinland also is a national resource to the many local/regional facilities.

Question 3. A new facility is not needed and is a Taj Mahal. How much time was spent each day on a bus during transportation to use community facilities?

Answer. 1½ hours.

Using the YMCA Camp Ihduhapi, how many wheelchair participants was Vinland restricted to?

Answer. 5-6.

Was the YMCA-Ridgedale completely adequate for beginning healthsports instruction?

Answer. No.

Will approximately $70.00 per foot build a Taj Mahal?

Answer. No.

The Vinland National Center needs its own building. Too much time is spent on a bus, wheelchair users have been turned away due to lack of accessible space and pool temperature which excludes quadraplegic and other disabled persons from swimming. These are only a few of the rationale for the needed building. $70.00 per foot in today's construction costs is considerably less than standard market rates. A national center requires more than a private home converted into a conference center and a four stall garage converted into an eleven desk office.

Question 4. The Vinland National Center is not cost effective and funds should be spent elsewhere. How does the cost per day at Vinland compare with local rehabilitation facilities cost per day?

Answer: The pilot programs of the Vinland National Center cost per person per day were $53.28. This compares with approximately $90.00 per day of the Courage Center and $330.00—$385.00 of rehabilitation hospitals.

The funds allocated for Vinland would be better spent elsewhere.

Answer: Earlier today you heard a plea to use these funds elsewhere. All of the suggestions were aimed at severely mobility-impaired persons. But what about persons with hearing or visual impairments, epilepsy, retardation and the other countless disabilities served by the Vinland National Center? Healthsports are for all persons regardless of ability; $5.3 million is not a lot of money. These funds will benefit 5,000-10,000 persons of all types of disabilities each year. These persons will through Vinland's outreach for the years to come be serviced (?) without costing the Federal Government a dime!

I believe this issue to be moot.

Question 5. Don't Start a New Program: Is a program sponsored by the country of Norway, the State of Minnesota, RSA and HDS since 1976 a new program?

Answer. No.

Is a program that has spent one year to organize the necessary support, spent two years planning operational and architectural programs, conducting Needs Assessments, Spent one year testing each program component separately, and has completed a federally funded series of pilot programs during the last year to verify that the concept brought from Norway will work in the United States; is such a program a totally new program?

Answer. I think not.

Can the Vinland National Center recruit participants for its pilot programs with only 2½ months lead time?

Answer. All courses were completed.

The Vinland National Center is an existing program that has evolved carefully and now has come to the United States Congress, with our plans and programs, that have been developed, tested and proved effective, for your review and funding.

Question. 6. How will the Vinland National Center be self-sufficient after the 5 year period?

What are the funding sources?

Answer. Fees for service; Third party payments; Professional training workshop fees; Publications, such as training manuals; Research grants; Annual Skiathon proceeds and Sons of Norway support; and Adapted equipment sales.

Private insurance companies have already funded the travel and tuition costs of their clients' stay at Vinland. This will only increase. Illinois State Vocational Rehabilitation funded a participant. As the Vinland National Center research is completed and the positive results of healthsports and lifestyle changes are documented, this area of funding will increase.

Question 7. Vinland is for Able-Bodied Persons. Is it effective to train professionals to offer healthsports in their programs?

Answer. Definitely!

Is it effective to train a blind person to ski and not teach a sighted person to guide?

Answer. No.

Should disabled persons live in a totally disabled world?

Answer. No.

The programs at Vinland are open to disabled and able bodied persons. This includes family members, friends and professionals who are training with the disabled persons so that there are persons in the home community who have shared the Vinland experience.

Question 8. Vinland doesn't have its Certificate of Need. The Certificate of Need application can't be reviewed nor granted until the funding for construction has been finalized. Besides, the Minnesota State Legislature has abolished the Certificate of Need requirements in 1982.

I appreciate this opportunity to address this committtee. The Vinland National Center is an exciting and unique program. Vinland challenges the body, mind and spirit. It captivates many regardless of ability, and changes their lives. It has changed my life as it will change many others. I know Congressman Erdahl has felt this feeling, and now H.R. 6820 will provide the opportunity for those who haven't yet experienced the Vinland programs.

Mr. ERDAHL. Just a couple of other comments and questions, the first one to Phil Carpenter. Thank you very much for being with us today. One of the concerns some people have expressed and I recognize the legitimacy of their concern and the sincerity of it, really is that we have to be very careful in this time of austerity that we don't duplicate facilities.

I wonder in your travels, is this center here as unique as some of us like to think, and could you explain if you would in your own words on the need as you see it for something like this, and are we in danger of duplicating facilities and can we better coordinate activities from a center like this and other facilities dealing with serving the handicapped?

Mr. CARPENTER. From my experience, I have had, as I mentioned, I have had to learn a lot of things from just experimentation. I have traveled around the country and some of the activities that I have participated in, canoeing, kayaking, hiking, have been that I happened to know somebody. And through my traveling and through sports I started wheelchair racing actively in 1977.

In the different parts of the country I have traveled through, I met these persons. There are a lot of people—I have gotten letters from Nigeria and Austria asking how can we develop wheelchair racing programs? That is my expertise.

So there is a need for a national center in the country. People just call me and I am getting letters, "Where can I go for information on training or for some other activities?" I don't believe the service is being duplicated anywhere.

I have worked with the Spinal Cord Injury Advisory Council in the State of Florida, and they are developing their State plan, which deals with acute care and with the rehabilitation processes, but they don't make provisions for the continuing rehabilitation processes.

I found that perhaps the first 4 years in a person's new life as a disabled individual—I am speaking from experience—resulting from a trauma, that the first 4 years are probably the toughest, when most adjustments have to be made.

There weren't—there were no services available to me to help me in that adjustment, and that has been one of my personal goals, is to try to help newly injured folks to realize their capabilities and get them interested in sports or other recreational activities so that it gives them an outlet and some means to achieve more self-esteem rather than groping in the dark.

Mr. ERDAHL. So you are saying there is a spinoff from participating in sports? Obviously, it has been that way for you?

Mr. CARPENTER. Certainly. As I mentioned, the first 4 year thing—I didn't get started into sports until I had been injured just about 4 years, and from that point on, it really made a big different in the way I felt about myself and about my abilities and how I related to others in the community, especially through the road racing participation.

The other programs developed here, such as the skiing and that type of thing, are not such as the wheelchair basketball program, which is probably the largest single sports program in this country, 150 teams in the country, but that is isolated only to disabled persons.

That is available only to those people, whereas in the road racing I am integrated with the community. I don't need a team to participate. With the skiing, I don't need a team to participate. I can participate alongside friends and neighbors from the community.

This is where we are talking about getting involved with local community organizations, also.

Mr. ERDAHL. A couple more points, one to thank my former colleague from the legislature, Jim Swanson, for being here and for the leadership that you have shown in this area from its inception. Dr. Vanden Brink, to thank you for being here. I have a question.

I think it is great that we have institutions like the Gillette Hospital and others that are participating. We have had examples of the fraternal organizations, the association people you represent.

I mentioned to Dr. Vanden Brink, my twin brother was once a patient with polio in the Gillette Hospital. Do you see a coordinated activity of referring people going on? Gillette Hospital used to be the Gillette Hospital for Crippled Children?

Dr. VANDEN BRINK. It started in 1897 as the——

Mr. ERDAHL. I am not quite that old.

Dr. **Vanden Brink**. A State hospital for the indigent crippled. Today, I want to develop Gillette into more than that. We are working on a new rehab program that is going to include adolescent medicine, because that is the one we see we have failed on.

Why is he on the drugs and why is he doing those things? We have somehow failed. I think it is this vague thing that you have asked Phil about, the self-image and a difficult area to define, but recognized more and more as important.

So our rehab program will include a move into the Vinland Center. The age is not defined, but they have been adult-oriented. We are trying to talk Vinland into being child-oriented in terms of getting them out here at 12 or 13 and getting that image created early and they will enter into their teens with a more positive attitude than we would be able to achieve in a hospital setting.

Mr. **Erdahl**. Dr. Dahl nodded. Do you agree with the concept to involve younger people?

Dr. **Dahl**. We have had participants down to the age of 9. One has to revise that Bietostölen was born in turmoil. The Norwegian association boycotted the center because they felt threatened by its presence.

Three years later the president of the association was on the board of the center and the turmoil was gone, and it was a hand-in-hand relationship, and it has persisted since. I fully expect that there will be turmoil here, too, and I fully expect it will be resolved the same way.

Mr. **Murphy**. How many trainees do you have here now?

Ms. **Saari**. At the moment none, because the Y camp is having camp. When we start on September 26 with our onsite programs, we will have about 22 at any given time at the center.

Mr. **Murphy**. Are they in residence?

Ms. **Saari**. Yes, using the YMCA camp which is right next door.

Mr. **Murphy**. Well, we will be submitting our written questions to you, Doctor, and we will look forward to your visit when you come to Washington.

Ms. **Vincent**. All the testimony that has been given this afternoon, you mentioned the uniqueness of the Vinland plan and philosophy, and I really question it. The programs are being carried on at many other places throughout the country, including Courage Center and Sister Kenny. The sports programs are not unique to them.

The physical plant is, I still say, not necessary. The replication of programs throughout the country makes sense, but you don't need to build a multimillion-dollar facility to do that here, because the facility already exists in many other places where this could be carried on.

If you wanted to have onsite training in term of a gymnasium, a swimming pool and that kind of thing——

Mr. **Murphy**. Will you send us a letter and give us the names of the other sites so we can have our staff check them out?

Ms. **Vincent**. They exist in every city throughout the country. Also, I wonder—Tom Haven was unable to be here this morning. He is the president of the Metropolitan Handicapped Coalition.

Mr. **Murphy**. We would like to have his written testimony if he would care to send it in and it will be made a part of the record.

Ms. **Vincent**. Fine.

Mr. **Murphy**. If you will send it to our offices in Washington, D.C., it will be made a part of the record and read by not only the two of us here, but it also will be read by other members of the subcommittee as well as the full committee.

If there is nothing further, we thank all of the panelists and visitors and guests. We thank you very much for the use of these facilities today for this hearing.

[Whereupon, at 3:35 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

American Foundation for the Blind, Inc.,
Washington, D.C., September 29, 1982.

Hon. Austin Murphy,
Chairman, Subcommittee on Select Education,
House of Representatives, Washington, D.C.

Dear Mr. Murphy: I am writing to express the support of the American Foundation for the Blind, Inc. for Title I of H.R. 6820. As you know, Title I of this bill would establish the Helen Keller National Center for Deaf-Blind Youth and Adults as a special institution in the Department of Education.

The Helen Keller National Center for Deaf-Blind Youth and Adults and its affiliated network provide a unique service to individuals whose combined major handicapping condition of deafness and blindness requires highly specialized professional services to assist them to rehabilitate themselves and become active participating citizens in the life of their communities. The Center has already assisted a number of deaf-blind persons to become gainfully employed in competitive industry and has assisted many others to work in sheltered employment settings. Without the Center, many of the persons served would be unable to function at a normal level of activity and would be a burden to their families.

It should be emphasized that the Center is the only facility of its kind in the world and serves as a model of program activity for professionals working with deaf-blind persons in other countries.

As a result of budgetary cuts in recent years in special programs under the Rehabilitation Act of 1973, the Center has suffered from reductions in operating funds which are a threat to its effectiveness. We sincerely believe that establishment of the Center as a special institution with its own authorization of appropriations would enable it to continue its vital work on the basis of justification of its own activities to the appropriations committees. We therefore urge favorable action by your Subcommittee and the full Committee on Education and Labor on Title I of H.R. 6820.

We would appreciate having this letter made a part of the record of hearings on H.R. 6820.

Sincerely yours,

Irvin P. Schloss,
Director,
Governmental Relations Department.

AUG 26 1982

HARMARVILLE REHABILITATION CENTER, INC.
P.O. Box 11460, Guys Run Road, Pittsburgh, PA 15238
(412) 781-5700/828-1300
ADDING LIFE TO YEARS

August 20, 1982

Congressman Austin Murphy
U.S. House of Representatives
Washington, D.C. 20515

Dear Congressman Murphy:

As a representative of the Harmarville Rehabilitation Center, I am writing to express my support of the Vinland National Center and the proposed Handicapped Individual Services Training Act, H.R. 6820.

Harmarville Rehabilitation Center provides a comprehensive array of services in order to assist the physically disabled in improving the quality of their lives. Recreation, fitness, sports, and social programs are an integral part of our rehabilitation program.

The Vinland National Center is a valuable resource for rehabilitation professionals and persons with disabilities. The concepts which Vinland represents, health promotion, health sports, recreation, and life enhancement, compliment and extend individuals beyond rehabilitation goals.

Since its development, Vinland has contributed a great deal of expertise and information to facilities such as the Harmarville Rehabilitation Center. The programs and services which they provide can have a significant impact in improving a disabled individual's physical condition, adjustment, and lifestyle.

I support, without reservation, the Handicapped Individual Services Training Act and the financial resources which the ACT will provide to the Vinland National Center.

Sincerely,

Deborah A. Hutchins

Deborah A. Hutchins, MTRS
Director, Recreation Therapy

DAH/vle
cc: Arlen Erdahl

AUG 30 1982

SCANDINAVIAN AIRLINES OF NORTH AMERICA INC.
138-02 QUEENS BOULEVARD
JAMAICA, NEW YORK 11435

B. J. HEISTEIN
PRESIDENT

August 27, 1982

The Honorable Austin Murphy
Representative in Congress
Washington, D. C. 20025

Dear Sir:

I understand you will be conducting a Congressional Committee Hearing on H.R. 6820 regarding the Vinland National Center. I am delighted to hear you are taking an interest in this very worthwhile undertaking and I hope you will have a chance to visit Vinland and see it for yourself.

For your information, I visited Vinland with my wife last June and spent a day watching their program and their students, and it left a very deep impact. They are in such desperate need of help and the unfortunate disabled people deserve that help so much.

I have written the enclosed article which will appear in the SAS house organ to employees in North America in the October issue. We are jointly going to try to raise funds for paving of one mile of trail. I have no doubt that we will reach that goal because our people, like Americans everywhere, respond wholeheartedly when the need is so obvious as it is for Vinland, and when the cause so worthwhile.

I hope you will take time to read it and I hope it will help give you a feeling of Vinland as my wife and I saw it.

Very truly yours,

B.J. Heistein

North
American
Division

The President's "E" Award
for Export Service

SAS
SCANDINAVIAN AIRLINES SYSTEM

SAS Building
138-02 Queens Boulevard
Jamaica, New York 11435
212/657-2675

TO: SAS Colleagues in North America

Have you ever sat fascinated from listening to a speech from a man who is both deaf and mute? Have you ever seen twenty severely disabled young men and women join together to put an inner-tube over the top of a ten foot pole? Have you ever seen people without legs lower themselves into a kayak and, for the first time in their lives, realize they can row it... or run a slalom competition in wheelchairs... or climb mountains?

I am fortunate, for I saw it... last May at The Vinland National Center in Minnesota. And, I have never been more impressed... and moved.

The story of Vinland itself is impressive. It started with the King of Norway giving a Bicentennial gift to America. Volunteers are doing the rest. Vinland National Center works through "healthsports" to provide recreation, physical conditioning, exercise and the joy of the outdoors for people whose handicaps might normally shut them away from it all. Vinland's unique approach is that it sets physical challenges that the disabled can overcome. It teaches the methods, the self-discipline and the self-respect that the handicapped might lack. And it gives them the joy and confidence of having achieved. It goes beyond that too. Their teach-the-teacher programs are reaching around the country now and the achievements are getting attention from Washington for possible future financial help.

Vinland is in no way an ethnic establishment. It has the support of the U.S. Department of Education, the University of Minnesota, the labor unions and many others. It has students from all over the country. And, it needs help from many more.

A few months ago the National Guard volunteered to spend their summer weekends clearing trails. But, to be used for biking, hiking, wheelchairing, and so on, the trails have to be paved. That costs Seven Dollars a foot, and Vinland is asking around the country to help by "putting a foot on the trail".

SAS Colleagues in North America
Re: Vinland National Center

This is not for luxurious outdoor fun. This is for life in the raw, as it is for those who are physically disabled. To help them help themselves...

Perhaps we, as fellow employees, could help? How about an SAS Employees Trail?

I know we all get requests for contributions every day. And, I know that charity begins at home. And, I also know that all of you in your heart will like nothing more than to help those who -- through birth or accident -- are confined to a very rough lifestyle. We have a chance to help change it for a lot of them... by "putting our foot on the trail".

I am sending my coupon in today... will you join?

Best regards,

B.J. Heistein

B. John Heistein

Tear here and return to:
VINLAND NATIONAL CENTER
3675 Ihduhapi Road
P. O. Box 308
Loretto, MN 55357

Please make checks payable
VINLAND NATIONAL CENTER

_____ YES! I WANT TO PUT MY FOOT ON
THE VINLAND NATIONAL CENTER
SAS EMPLOYEES TRAIL

$_______ is enclosed @ $7.00 foot. My payment is for ________ feet.

NAME: ____

ADDRESS: ____

CITY: ________________ STATE: ____________ ZIP: _______

_____ Please add my name to
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Harmarville Rehabilitation Center • P.O. Box 11460 • Guys Run Road • Pittsburgh, PA 15238 • (412) 781-5700/828-1300 Ext. 234

ACE
Accessible Community Experiences
A Community Oriented Recreation
Program for the Physically Handicapped

August 23, 1982

Congressman Austin Murphy
U.S. House of Representatives
Washington, D.C. 20515

Dear Congressman Murphy:

On behalf of Project A.C.E. (Accessible Community Experiences), we ask that you support Congressman Arlen Erdahl's legislation - H.R. 6820, The Handicapped Individual Services Training Act - that would earmark $5.3 million in federal funds to help complete the Vinland National Center, a health and sports center for the handicapped in Loretto, Minnesota.

The Vinland National Center has opened many doors to recreational activities across the nation, that many disabled persons have never before considered. One such event was a 3 day Sled-Skiing Workshop that Vinland National Center helped us to sponsor earlier this year in Pittsburgh, Pennsylvania. Sled-Skiing is a relatively new sport on the eastern coast and has never been done before in the Pennsylvania Tri-State area.

Along with providing recreational programs for the handicapped, Vinland has done an outstanding job in educating abled-bodied persons and the community to the potentials and opportunities available to our nations disabled population.

Congressman Erdahl's legislation would help Vinland become fully operational as a National Resource by providing a more dependable source of federal funding. Under Erdahl's bill, the federal share of Vinland operating costs would be steadily reduced and finally phased out after five years.

This is a critical time in the development of the Vinland National Center. Your support and cooperation with H. R. 6820 would be greatly appreciated. If you have any additional concerns or questions, please contact Project A.C.E. at Harmarville Rehabilitation Center, 781-5700/828-1300 ext. 234.

Sincerely,

Frank Bisceglia, Jr.

Frank Bisceglia, Jr.
Director: Project A.C.E.

FB/klc

cc: Arlen Erdahl

AMERICAN COUNCIL OF THE BLIND

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October 26, 1982

The Honorable Austin J. Murphy
U.S. House of Representatives
Washington, D.C. 20515

Dear Representative Murphy:

The American Council of the Blind, the largest organization of blind and visually impaired people in the United States, urges your support of H.R. 6820, the Handicapped Individuals Services and Training Act. We believe that this legislation is important to our constituency in two important respects.

First, an independent permanent authorization for the Helen Keller National Center for Deaf-Blind Youths and Adults will help isolate this important program from the disproportionately high budget cuts imposed on discretionary programs under the Rehabilitation Act in recent years. Adequate specialized services to deaf-blind persons are essential in order for such individuals to maximize their quality of life and employment potential.

Second, a five year authorization for the Vinland National Center for physical fitness and health sports for handicapped individuals will enable many blind and visually impaired Americans to enjoy benefits of health, education and recreational activities in an integrated setting with non-handicapped individuals. Leisure time activities are important to good mental and physical health, and this is particularly true for those who, because of vision problems or other physical limitations, may have difficulty in competing in competitive sports activities without special training or assistance. Further, the education program which the Vinland National Center is expected to provide will greatly increase the opportunities for the blind and vsiually impaired to live the type of life style that is a necessary prerequisite for a healthful, happy, productive and dignified life.

The American Council of the Blind looks forward to cooperating with you toward passage of H.R. 6820. We would appreciate hearing from you as soon as possible concerning your anticipated support of this legislation.

Yours sincerely,
Oral O. Miller
Oral O. Miller, J.D.
National Representative

cc: Grant Mack, President, American Council of the Blind
Joan Saari, Director, Vinland National Center
Mary Ballard, Editor, The Braille Forum

THE SECRETARY
WASHINGTON, D.C. 20202

DEC 9 1982

The Honorable Carl D. Perkins
Chairman, Committee on Education
and Labor
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

This is in response to your request for a report on H.R. 6820, a bill entitled "Handicapped Individuals Services and Training Act," as marked up by the Committee.

In summary, we strongly oppose the establishment of new authorities for the four programs encompassed by H.R. 6820. This Department considers that the objectives envisioned by the proposed legislation can be realized under existing laws, namely the Rehabilitation Act of 1973 and the Education of the Handicapped Act (EHA).

To respond fully to your request for comments, we will address each title in H.R. 6820, discussing the Federal organizational assignment, funding levels, and reporting and monitoring requirements proposed for each of the programs.

Title I - Helen Keller National Center for Deaf-Blind Youths and Adults

The proposed legislation would repeal section 313 of the Rehabilitation Act under which the Helen Keller National Center is currently funded, but it would not alter the basic purposes of the Center. As under the Rehabilitation Act, H.R. 6820 would provide specialized intensive services, train personnel, and conduct applied research relating to deaf-blind individuals.

A program for the Center has functioned under section 313 for more than a decade to carry out the responsibilities specified in H.R. 6820. Appropriations for the Center in fiscal year 1982 are $3,13[illegible],000; the authorization level for fiscal year 1983 is $3.5 million, which is both consistent with the level established under the Omnibus Reconciliation Act of 1981 and identical to the level proposed in the bill for fiscal year 1984.

We believe that it is desirable to continue to provide Federal assistance to the Center. However, we believe that the Center has been, and will continue to be, successfully administered under the Rehabilitation Act.

Title II - Vinland National Center for Healthsports and Physical Fitness for Handicapped Individuals

Title II of the bill would establish a national center to provide training in physical fitness for handicapped individuals. The Center would also offer technical assistance to establish programs for similar activities in basic and applied research in this area, and would collect and disseminate information relating to physical fitness throughout the United States.

The Department regards the Federal role concerning the recreational needs of handicapped individuals as limited to research and demonstration activities which can be adequately carried out through existing legislation. Demonstration and model projects could be authorized under title III of the Rehabilitation Act. For example, in 1981, $3 million was appropriated for demonstration and special recreational projects benefitting approximately 48,000 handicapped individuals in thirty-three geographically dispersed programs. Further, the National Institute of Handicapped Research, established under title II of the Rehabilitation Act, plans to include as one of its future priorities research concerning the recreational and physical fitness needs of handicapped individuals, including the collection and dissemination of research findings.

This Department believes that there is no need to establish a national center for physical fitness, dependent upon Federal assistance for ongoing support. Physical fitness and recreational activities are more appropriately a responsibility of the States, which are better able to determine the service needs of their handicapped citizens.

In addition to our general opposition to title II of the bill, we object to the specific administrative requirements of this title, which include a National Advisory Panel, detailed matching and other budget requirements, annual independent audits, and on-site monitoring. These requirements are burdensome, intrusive, and overly prescriptive. While we generally support monitoring and evaluation provisions, we object both to the specification of the number of on-site monitoring visits to be accomplished within a given period of time, and to the annual evaluation and reporting requirements in the bill. Further, we think that decisions regarding the organizational units administering programs within the Department should be left to the discretion of the Secretary.

Title III - Regional Postsecondary Educational Programs

Title III of the bill would establish a separate authority for a program already authorized under section 625 of EHA. The regional education program envisioned by both EHA and the proposed legislation provides for two areas of assistance -- support for several vocational institutes or colleges for the deaf, and support for a variety of demonstration projects.

As written, the proposed legislation would repeal section 626 of EHA (the repeal of section 626 rather than section 625 appears to be a technical error), but would authorize a program which is very similar to what may be accomplished under current law.

Authorization levels for the program are consistent with the level of authorization for section 625 of EHA. As with title II, while we have no objection to certain monitoring activities, we find that the annual evaluation and reporting requirements of this title are burdensome and unnecessary. In addition, as in title II, we oppose specific, statutory, organizational assignments which we believe should be left to the discretion of the Secretary.

Title IV - Captioned Films and Related Services for Deaf and Other Handicapped Individuals

The program envisioned in title IV of H.R. 6820 is quite similar to that currently authorized under section 652 of EHA with two significant exceptions. First, under H.R. 6820 a general authorization for activities relating to educational media would replace specific authorizations for research and training in that area. Second, a separate authorization of appropriations for captioned films and educational media would replace an authorization of appropriations that covers these activities and those under section 653 of EHA which authorizes establishment and operation of centers on educational media and materials for handicapped individuals. However, the activities contemplated under H.R. 6820 could most likely be implemented under the general authority already included in EHA.

As with titles II and III of the bill, the Department believes it is inappropriate to designate an officer below the level of Secretary to administer the program.

Since H.R. 6820 would not repeal section 653 of EHA, and would leave the current authorization of appropriations for Part F of that Act in place, the combined funding level for title IV of H.R. 6820 and the residual activities under Part F would be $36.5 million. This level is excessive when compared with the fiscal year 1982 appropriation of $11.5 million for essentially the same activities.

Further, the proposed legislation would increase administrative burden without a compensating improvement in program operation. Existing legislation maintains an important interrelationship between media acquisition, distribution, research, and development. To the extent that there is a fragmentation of these activities under separate laws, services to handicapped individuals will suffer.

For the reasons outlined above, the Department of Education strongly opposes H.R. 6820. The goals of the proposed legislation can be achieved through existing laws.

We are advised by the Office of Management and Budget that there is no objection to the submission of this report from the standpoint of the Administration's program.

A copy of this report will be transmitted to Chairman Hatch of the Senate Committee on Labor and Human Resources, which is considering S. 2849, a bill very similar to yours, as introduced by Mr. Erdahl.

Sincerely,

T. H. Bell

December 10, 1982
Copy sent to Subcommittee on Select Education.